

Asylum Seekers and Primary Care in Malta: A Critical Exploration of Healthcare Encounters

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Abstract

There is a substantial body of literature that highlights disparities in asylum seeker health and healthcare access and the difficulties that healthcare professionals face when providing care to asylum seekers and refugee populations. Few studies, however, have explored these processes within the context of Maltese society. This study aimed to gain an insight into cross-cultural healthcare practices through an exploration of clinical encounters between asylum seekers and healthcare professionals in the primary health care setting in Malta.

The research design was guided by an ethnographic approach, with data collated through observation and in-depth interviews. The observational period consisted of one hundred and thirty hours spent mainly in a government Health Centre, with a focus on healthcare encounters between asylum seekers and healthcare professionals and included a series of informal conversations. Formal, semi-structured one-to-one interviews were carried out with 11 asylum seekers, two cultural mediators and seven healthcare professionals. Data were analysed inductively using thematic analysis informed by postcolonial and intersectionality theories within a candidacy framework.

The analysis produced three main themes, namely: “Seeking Refuge and Beyond – The Migratory Process”; “Seeking Mutual Understanding – Communicating within the Healthcare Encounter” and “Seeking Resolution”. The first theme provides the asylum seekers’ poignant testimonials of their pre and post migratory experiences, including both the perceived impact of these on their physical and psychological health and the healthcare professionals’ perspectives of the asylum seekers’ migratory journey. The second and third themes represent both asylum seekers’ and healthcare professionals’ experiences of, and practices within healthcare encounters, with narratives that show how both these groups have the common aim of achieving a satisfactory resolution to the presenting problem. Notwithstanding this, the three themes show the extent to which cross-cultural healthcare encounters fail to achieve this common aim because of a range of factors that impact on service provision and ultimately, on individual healthcare interactions. These findings have guided the creation of a multilevel framework that

illustrates the impact of various discourses and structures on the formation of an assortment of elements, which intertwine in a chaotic bricolage that ultimately shapes cross-cultural healthcare encounters. These elements include linguistic and cultural discordances, power asymmetries, trust/mistrust issues, incongruent expectations and issues of asylum seeker deservedness, being played out in an unsupporting environment.

The utilisation of a critical constructivist position that negates essentialist generalisations has enabled a multi-layered analysis that presents a counter balance to common culturalist explanations of healthcare encounters. Postcolonial theory has revealed how healthcare encounters are influenced by the colonialist creation of categories of 'Us' and 'Other' and an uncritical belief in the supremacy of 'Western' knowledge.

Recommendations are made for healthcare research, education, practice and policies. One of the recommendations is for the identification and implementation of an effective information system, which collects the necessary data to enable the development of services and practices that effectively address asylum seekers' primary healthcare needs. Other recommendations include the establishment of a working group with a remit to review existent structural systems and policies for their potential to produce inequitable and discriminatory healthcare practice within the primary setting, as well as identifying and implementing educational strategies that would produce reflexive healthcare professionals able to discern previously unquestioned inequities to challenge an unjust status quo.

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Chapter 1: Introduction

Introduction

The negative impact that migration can have on an individual's socioeconomic circumstances and health status has been found to be so significant that immigration itself has been identified as a social determinant of health (Castaneda et al, 2015). This is especially so for asylum seekers who are generally placed on the lowest rung of the migrant hierarchy (Piacentini, n.d.) and whose intersecting positionalities serve to raise further barriers on the various stages of the healthcare pathway through inequitable healthcare systems (O'Donnell et al, 2016). The healthcare encounter is a complex interaction that is influenced by a variety of personal and collective factors and is played out within a social, organisational and medical culture (Svenberg, Mattson & Lepp, 2013). This study examines asylum seekers and professionals' (HCPs) healthcare practices and provision through an exploration of healthcare encounters in the primary healthcare (PHC) setting in Malta.

This chapter provides an account of forced migration to Malta since 2002, followed by an overview of PHC and PHC Services. A justification for the choice of research topic will then be presented, as will be the aims of the study. The chapter begins with a brief description of the development of my personal interest in the topic under study.

Personal Interest in Research Topic

In her seminal essay "Can the Subaltern Speak", Spivak (1988) asserted that the production of knowledge can never be detached from its producer, or the underlying motivation for its production. In view of these assertions, this short section describes the trigger to my research interest and the reasoning that has led to the formulation of the aim and objectives provided at the end of this chapter.

A few years ago I attended a study unit on multicultural care provision, which required that I carry out a cultural assessment. The person that I interviewed for this assessment and

whom I have named Joe, had been born in Liberia where he had lived for ten years. Following the outbreak of civil war he fled to Ghana and lived there as a refugee for 17 years. Joe then came to Malta and when I interviewed him he had just been released from the closed detention centre, where he had spent over 1 year and was presently living in an open centre. This interview served as an eye-opener for me, making me acutely aware of my own cultural incompetence; an incompetence which I initially ascribed to a lack of cultural knowledge. On further reflection, I realised that the acquisition of cultural knowledge alone would not suffice. This realisation, in addition to a recognition of the growing xenophobia and racism amongst the Maltese population in response to an influx of asylum seekers travelling by boat from Libya to Malta (Cardona, 2010), fuelled my interest in this field.

Asylum Seekers' Migration to Malta since 2002

Malta is an archipelago that includes three populated islands namely Malta, Gozo and Comino. With an area of 316 square kilometres and a population of 429,344 in 2014, it is both the smallest, as well as the most densely populated of the countries in the European Union (National Statistics Office (NSO), 2016). Malta is situated in the middle of the Mediterranean Sea and because of its strategic geographical position has undergone centuries of domination, finally becoming an independent state in 1964 and gaining accession to the European Union (EU) in 2004.

In 2002 Malta experienced an unprecedented arrival of over a thousand, mainly African asylum seekers by boat, and apart from an inexplicable decrease in 2003, this influx rose steadily till 2008, with the number of arrivals for that year standing at 2,775. In 2009 and even more so in 2010, these numbers were drastically reduced because of a controversial agreement between Italy and Libya (United Nations High Commissioner for Refugees (UNHCR), 2016a), which was in violation of international law and aimed to stop asylum seekers from reaching Europe by strengthening border patrols and returning all apprehended migrants to Libya (Human Rights Watch, 2009). Notwithstanding this, the numbers of 'boat people' started to rise again following the Arab Spring in 2011 (Micallef & Peregine, 2013). These figures once again started to decrease steadily in 2014, with only

one family of five arriving by boat in 2016 up until June, while all other individuals who applied for asylum during that period were non-boat arrivals (UNHCR, 2016b). Until the end of 2013, over 80% of these migrants hailed from Somalia, Eritrea, Nigeria and Mali (UNHCR, n.d.), with this pattern starting to change in 2014. Indeed, statistics showed that the top asylum applications for the first six months of 2016, originated from Libyan nationals, followed by Syrians and then by Somalis (UNHCR, 2016b).

For sub-Saharan African asylum seekers¹, the escape from their country of origin is generally followed by a perilous journey across other African countries, often ending up in Libya, where they are indefinitely detained and subjected to various forms of abuse (Amnesty International, 2010, 2016). In desperation, these migrants attempt to cross the Mediterranean sea, often on unseaworthy boats resulting in a high death toll, with a conservative estimate of over 9000 individuals having died, or gone missing between 2010 and 2015 (UNHCR, 2016a). For the majority, if not all of these ‘boat people’, Italy is the destination of intent and they land in Malta either because their boat is in distress, or because they mistake it for Italy (Gatt, 2012).

Politico-Legal Considerations

Whilst the total number of sea-borne arrivals to Malta cannot be said to have been extremely high, these numbers change in significance when one takes the island's' size and population density into consideration (Ministry for Home Affairs & National Security, 2015). Indeed, the unsustainability of the number of irregular migrants is one of the major arguments that two successive Maltese governments have utilised in an attempt to put pressure on European member states to undertake greater burden sharing (Gonzi, 2007; Dalli, 2013). In a poll carried out in June 2015, immigration was still cited by the population as one of the major concerns that Malta is facing (“Immigration, environment and traffic, are main issues in Malta – survey”, 2015). The demand by the Maltese and other governments for greater burden sharing is a consequence of the obligations that the

¹ Data collection for the present study was carried out in 2014 and therefore the asylum seekers who participated in this study are represented mainly by individuals who had travelled to Malta by boat from sub-Saharan African countries.

Dublin II Convention has on these border countries (Mouzourakis, 2014). This convention places the responsibility for processing asylum applications on the country of first entry and the obligations to this Convention are further enforced with the implementation of the Eurodac System, which is a database of biometric fingerprints and through which migrants who have escaped from their first country of entry are identified and sent back (Europa, n.d.; Vella, 2010). The Dublin II Convention has been greatly criticised by Malta and other southern EU border member states, which are the main recipients of these asylum seekers. Whilst The EU Commission has acknowledged the additional burdens that certain countries face and has encouraged the implementation of voluntary resettlement to other countries (Collett, 2010), the international response to voluntary resettlement in the past has been limited (Calleja and Lutterbeck, 2008) and has continued to be so up until May 2016, despite new emergency resettlement and relocation plans (European Commission, 2016). These criticisms have led to the Dublin III Convention but The Jesuit Refugee Service (2013), amongst other organisations, have called for amendments to this latter convention on humanitarian grounds, as they claimed that the policy is based on the false assumption that protection for those who need it is readily forthcoming.

A great majority of the migrants coming to Malta by boat apply for refugee status and with Malta's adoption of the first Refugee Act in 2000, all applications for asylum have been fully processed by the Office of the Refugee Commissioner since 2002. Whilst it is only a small number of the applicants who were granted refugee status between 2002 and 2012, over 50% of the asylum seekers were granted subsidiary, or humanitarian status. These are temporary forms of protection which are granted to asylum seekers who are not deemed to warrant refugee status but who, due to a variety of reasons, would be placed in a dangerous position if sent back to their country of origin (Ministry for Home Affairs & National Security, n.d-a). Both of these statuses provide the asylum seekers with legal entitlement to remain in Malta temporarily until it is deemed safe for them to be returned to their country of origin (Agency for the Welfare of Asylum Seekers (AWAS), n.d.-a).

Refugee status enables the individual to reside in Malta with access to free education and health care services, work permits and unemployment benefits (Texeira, 2006).

Humanitarian/subsidiary status allows for access to “core welfare benefits” (p 71), although the extent of these are unclear, with various interpretations being made by different agencies (Advocacy Network on Destitution (ANDES), 2010). Additionally, this status is temporary and subject to review (Farrugia, 2009). Rejected asylum seekers are those whose application for asylum has been rejected, both initially and on appeal, and in these situations voluntary repatriation has been cited as the preferred solution, although deportation is also an option (UNHCR, 2014). However, repatriation of asylum seekers from countries that do not have a cooperation agreement with Malta is often not possible and these are awarded temporary humanitarian protection – new (THP –n)², which allows these individuals to work but whose entitlement to a number of other basic services despite them paying tax and national insurance, is unclear (“No status, no benefits, no way to return home”, 2015). With variable and limited access to free fundamental services, no means of getting back to their country of origin and minimal chances of escaping to mainland Europe, these rejected asylum seekers are veritably trapped in “a state of limbo” (Cameron, 2009 p21).

Similar to other Southern European countries, Malta’s historical migratory pattern is one of emigration (Icduygu, 2007) and with islands generally being disinclined to deal with immigration, asylum seekers are often viewed by the Maltese as a menace (King, 2009). Indeed, results of a survey on attitudes towards migrants, published by the Ministry for Social Dialogue, Consumer Affairs and Civil Liberties (MSDC) (2015a), showed how the participants differentiated between diverse migrants, with those who entered Malta “irregularly” (p 31) viewed in a negative way. The perceived threat that the arrival of these ‘irregular’ migrants poses, has been further amplified by Malta’s accession to the European Union and hence, the possibility of the free entry of people from the other member states. Indeed, Baldacchino (2009) claimed that “fear of invasion” (p157) by other Europeans was one of the major public concerns linked to EU accession. Thomson (2006) further stated that these fears have resulted in the adoption of a “protectionist stance” (p 5), as evidenced by both the moratorium on free entry to Malta for the first seven years of EU accession, as

² In November 2016, the Maltese government declared that any expired THP-n status would not be renewed and that after 31st October 2017, THP-n would cease to be an officially recognised form of protection (Borg, 2016).

well as the tough detention policy of all ‘irregular’ migrants up until December 2015. Subsequent to this, Malta’s reception strategies were restructured in concordance with directives that had been issued by the European Union (EU) (2013) and as of May 2016 there were only 3 detained individuals in Malta (UNHCR, 2016b). Notwithstanding this, a report by UNHCR, showed concerns about Malta’s present reception system because of a lack of clarity on certain issues, with further doubts being expressed on the system’s full legal compliance to specific aspects of detention (UNHCR, 2016c).

Detention

Malta’s previous detention policy dictated that irrespective of whether the ‘irregular’ migrant was an asylum seeker or not, they were to be kept in detention (Calleja & Lutterbeck, 2008), with the exception of those who were considered to be vulnerable, such as minors and pregnant women (JRS Malta, 2010). The detained asylum seekers were kept in closed centres for up to a maximum of one year until a recommendation of their application process was delivered. In the case of rejected asylum seekers, these were held in the detention centres for up to 18 months (Texeira, 2006).

The inhumanity of a strict detention policy, as well as the deplorable conditions of the detention centres in Malta, had been highlighted by both local and international organisations (JRS Malta, n.d.; Human Rights Watch, 2012, Kotsioni, Ponthieu & Egidi, 2013; United Nations, 2009). The inhumane conditions are clearly evident in a study carried out by the Jesuit Refugee Service Malta (JRSM) in partial fulfillment of a National Report on detention centres (JRSM, 2010). The findings from interviews carried out with 89 migrants living in three detention centres showed the daily strife of the detainees, who claimed that they experienced a total lack of information and lack of communication with the staff, a lack of hygiene, physical and verbal abuse and a lack of medical service provision. A report by Rossi and Caruana (2014) further illustrated the negative impact that these deplorable conditions have on the asylum seekers’ mental health and recommended that specialized mental health services be easily accessible in detention centres.

The Maltese government defended Malta's strict detention policy on grounds of national security and stability (Calleja & Lutterbeck, 2008, Farrugia, 2009), although this justification was refuted by some, who suggested that detention was being utilised as a deterrent, albeit unsuccessfully (UNHCR, 2013). Others further reported that detention only served to fuel the growing xenophobia and racism amongst the Maltese population, as a consequence of the depiction of asylum seekers as criminals (Cooke, 2014; European Commission Against Racism and Intolerance (ECRI), 2007) but as mentioned above, a new reception policy introduced in December 2015, brought an end to over a decade of asylum seekers being detained automatically (ECRE, 2016).

Open Centres

European directives stipulate that the host country is obliged to provide asylum seekers with the necessities that would ensure an acceptable "standard of living" and this includes the provision of adequate accommodation (Fondazzjoni Suret il-Bniedem, n.d., p7). Therefore, when released from either detention, or the newly established reception centre, asylum seekers who do not have alternative accommodation are housed in residential open centres and official statistics showed that by the end of 2009 the open centres and other similar institutional households in Malta, were housing 2,783 persons, 99% of whom were Africans (National Statistics Office, 2010). By May 2016, the number of residents at these centres had dwindled to 539 (UNHCR, 2016b), despite the availability of 2200 beds (AWAS, n.d.-b). This situation is possibly a reflection of both the decreasing number of asylum seekers coming to Malta, as well as the changing face of these migrants, with the majority of applicants hailing from Libya and arriving by plane (Vella, 2015).

The Agency for the Welfare of Asylum seekers (AWAS) is a corporate body that falls under the authority of the Ministry for Home Affairs and National Security and is responsible for the reception system and the eight reception facilities, which include the above-mentioned open centres (Asylum Information Database (AIDA, 2015). The largest centres are situated in Hal Far and Marsa, and in the past the inadequate conditions of these centres had been highlighted by diverse humanitarian organisations and in a variety of publications (ANDES, 2010; Amnesty International, 2010; Calleja & Lutterbeck, 2008;

Cameron, 2009; Texeira, 2006). These cited lack of privacy, lack of sanitation, lack of suitably qualified staff and a lack of recreational activities, as the main environmental concerns. Indeed, a participant in the ANDES (2010) study poignantly described the loss of dignity and the threat to self-esteem as a result of being expected to live in conditions well below Maltese standards. Since 2008, European funds have been provided for renovation projects to these main Centres (European Refugee Funds, n.d.) but despite this, a November 2015 country profile on Malta reported a great variation in the conditions between one centre and another, with some of the centres still found to be lacking, especially in relation to structural issues (AIDA, 2015). A substandard and inadequate physical environment was also found to be the most common complaint amongst the asylum seekers residing in specific open centres (Dalli, 2015) and especially so for those accommodated in the “mobile metal containers” (AIDA, 2015, n.p.).

Feelings of marginalisation and segregation from mainstream society have been cited as an outcome of living in the open centres, as is clearly evident in the findings of Cameron (2009), who interviewed five migrants at one of these centres with the aim of exploring their past and present experiences through narrative research. The author illustrated how the open centre represented both a “symbol of refuge and safety” (p 26) from a generally xenophobic Maltese society, as well as a “symbol of oppression” (p 27), as a result of being shunned by that very same society. Sammut (2009) highlighted the potential for these open centres to foster “ghetto-isation” (p 67), with subsequent repercussions of exclusion, discriminatory practices and ultimately, social fragmentation (Calleja & Lutterbeck, 2008). Other authors claimed that these centres are already, in reality, African ghettos (Cameron, Cardona, 2010), as evidenced by Cameron’s rich description of the centre being transformed into an “African Diaspora” (p 25), in response to these migrants’ being forced to live in a space, which despite being ‘open’, is ‘closed’ to any potential for integration into Maltese society. There is additional recent evidence to show that the integration of migrants is still problematic and according to the last Migration Integration Policy Index (MIPEX) (2015), Malta placed 33rd out of 38 countries with reasons cited including lack of a holistic integration policy and inequalities identified in relation to the attainment of migrant rights and opportunities. This shows that there has been negligible improvement when one compares these results to those of a similar study carried out five

years previously, with Malta placing 28th out of 31 countries (Huddleston, Niessen, Chaoimh & White, 2011).

Integration

Accounts of asylum seekers' feelings of frustration at their inability to break out of their present situation are numerous (ANDES, 2010; Amnesty International, 2010; Cameron, 2009; Cardona, 2010) and social invisibility has been cited as one of the major motivations for migrants on some form of temporary humanitarian protection to want to leave Malta (Skov, 2016). Micallef (2006) claimed that the resultant inequalities are a consequence of policies that are based on both governmental and populist prejudices and contempt and which, the European Commission Against Racism and Intolerance (2007) further stated, emanate from a discourse that fails to focus on "human rights and human dignity" (p 4). The importance of human rights is highlighted by Farrugia (2009), who claimed that this is an essential requisite for integration and furthermore, requires a commitment to equal opportunities, anti-discrimination policies and a recognition of diversity (European Commission Employment and Social Affairs DG, 2005). In view of the above and the increased suffering that asylum seekers in Malta face because of the lack of a comprehensive integration policy (Lutterbeck & Mainwaring, 2015), it is encouraging to note that the Ministry for Social Dialogue, Consumer Affairs and Civil Liberties (MSDC) (2015b) is currently developing a National Migrant Integration Strategy, following a public consultation exercise.

Employment, or more precisely, difficulties in finding regular employment, is one of the major reasons for the inability of migrants to rise above their present situation (Kalweit, 2009). Additionally, when employed, they are most likely to be involved in the underground economy, which is estimated at 25% of the Maltese gross domestic product (Calleja & Lutterbeck, 2008). The jobs found are temporary and are mainly in the construction and the tourism industry, with subminimal working conditions and wages (Cross Culture International Foundation, 2016). Additionally, the jobs that asylum seekers do get are often unsuited to their qualifications (Balzan, 2016). Other barriers to accessing the labour market include work permits, which whilst attainable vary according to

migration status, linguistic and cultural issues, and discriminatory practices (Debono & Garzia, 2016).

Despite all the populist fears of migrants taking jobs away from Maltese nationals, asylum seekers often take on the jobs that have been refused by the local workers and in so doing, help with the provision of cheap abundant labour that enables competitiveness (Icduygu, 2007). Moreover, in conjunction with the other categories of migrants, asylum seekers' participation in the workforce helps neutralize the effects of an aging population (Falzon, 2016a). In recognition of this, the trade unions have asked for a revision of the present work permit policies, which they claim enable exploitation of these workers (European Observatory of Working Life, (EurWORK), 2016). Additionally, a consultation document was issued by the Ministry for Education and Employment (2016) between April and May 2016, in relation to proposed strategies that aim to reduce the exploitation and irregular employment of migrants.

Accommodation is another area of difficulty for migrants and once they leave the open centre, it is very difficult, if not impossible, to be accepted back (AIDA, 2015), with the implications of this taking on extra significance in view of the insecure and temporary nature of their employment. Those asylum seekers who have been granted refugee status can register for social housing, but in these instances the waiting lists are very long. On the other hand, those migrants who attempt to rent a place independently either find it extremely hard to pay the high rents, or encounter landlords who are unwilling to rent to migrants from the Middle East, or Africa especially if they are black (National Commission for the Promotion of Equality, 2012).

Thomson (2006) argued that this exclusionary discourse is a consequence of Malta's protectionist stance and a study on integration policies in the EU by the European Commission Employment & Social Affairs DG (2005) highlighted the negative impact that this stance has on migrant integration with a resultant poverty risk. This poverty risk to migrants is evident in Malta and findings from Cardona's (2010) study clearly illustrated how a lack of integration has resulted in poverty for a substantial number of migrants. Integration is a multidimensional concept, which is determined by various political,

economical, societal and cultural factors such as legal status, political involvement, employment, education, health and social cohesion (European Commission Employment and Social Affairs DG, 2005). All of these have been found to be problematic with regard to integration in the local milieu (Farrugia, 2009) and which Cardona (2010) claimed is a consequence of the xenophobia that is held by Maltese society at large.

Xenophobia and Racism

Whilst the response of Maltese public opinion to irregular African migrants was initially one of sympathy, this reaction rapidly changed to one of xenophobia and racism, as a consequence of the steady increase in the number of asylum seekers arriving in Malta by boat (Falzon & Micallef, 2008; Frendo, 2006). Amore (2005) claimed that this xenophobia and racism is especially directed towards Africans, possibly in response to the political rhetoric enforcing images of ‘us’ and ‘them’ and a past history of negative encounters with Turks and Arabs (Texeira, 2006). A survey conducted by sociologist Professor Mario Vassallo appears to partially confirm Amore’s claims. Findings from this telephone survey that utilised a sample of 300 respondents, showed that whilst 95% of the respondents say that they would accept having a European neighbour, 95.3% claim that it would be highly undesirable to have a Palestinian neighbour, followed by Arabs generally (93.7%), then Africans (90%) and then Jews (89%). Further findings showed that only 21% of the respondents would be ready to provide protection to asylum seekers and when asked whether “skin colour” should be a consideration for a decision on status, only 17.3% gave an unequivocal negative reply (“Maltese intolerant towards foreigners”, 2005, n.p.). Grima claimed that Malta’s racist attitudes towards Arabs and Africans is a strategy that is utilised by the Maltese population in an attempt to elevate their self-perceived lowly position, which has arisen out of a past history of colonisation (as cited in Choteau, 2005).

A report published by the Office of the United Nations High Commissioner for Human Rights (OHCHR) (2015), based on a fact finding mission carried out in December 2014, asserted that the Maltese public generally perceive asylum seekers to be criminals, or a threat to job availability, or riddled with disease. This corroborated Sammut’s (2007) earlier claims of the xenophobia arising from a public perception of the social and

economical impact that these migrants would have on Malta, while Thomson (2006) further attested that this xenophobia has emerged from a general belief that the presence of migrants poses a threat to social cohesion and national identity. King (2009) validated this statement when he reported that the challenges of irregular immigration to Malta are heightened by the fact that till recently, Malta was composed of a relatively homogenous society, albeit with a fragile national identity; a fragility which is possibly the consequence of a country that is “deeply divided along party-political lines” (Mitchell, 2003 p379) and which, coupled with the EU accession campaign, has given rise to endless debates on the characteristics of a Maltese identity (Mitchell, 2003). These debates are divided into two opposing discourses, with one side claiming that the Maltese have a strong sense of their identity (Abela, 2005-2006; Cassar, 2000; Frendo, 2008), and with the other side claiming that the Maltese peoples’ approach to their identity is very ambivalent (Baldacchino, 2002; Mitchell, 2001). Indeed, Baldacchino (2009) asserted that it is only recent events, such as the adoption of the euro currency and the increase in asylum seekers, which have propelled the Maltese into searching for some form of unified identity. Gerber (2010) reported that Maltese national identity itself was never an issue because of the well-defined boundaries of the island and further asserted that the real issue was where Malta’s international allegiance and identity lay.

Notwithstanding this, all the proponents of the above-mentioned discourses agree that Catholicism plays an important role in nationalist pride and that the influx of asylum seekers is perceived by the Maltese populace to pose a threat to the Catholic values they deem to hold, and is further viewed as an assault on religious homogeneity (Gerber, 2010; King, 2009; Sammut, 2007; Thomson, 2006). Furthermore, despite a change in the Maltese population’s approach to the Roman Catholic religion, in terms of religious practices (Chetcuti, 2015; Debono, 2016) and a decrease in the number of believers (Debono; Leone-Ganado, 2016), religion is still being used by some to instill a fear of invasion by people who are ‘different’ (Balzan, 2016). In addition to the Catholic Church, both Baldacchino (2002) and Falzon and Micallef (2008) further named the two major political parties, as proponents through which public opinion is formed, with their policies and discourse potential contributors to the growing xenophobia (Jones, 2008). A clear example of this occurred in July 2013, when the prime minister of Malta threatened to pushback

Somali asylum seekers who had just arrived on a boat. Whilst this threat was condemned by 11 Maltese NGOs who alerted the European Court of Human Rights of this violation and further provoked a petition signed by just over 2000 people (ECRE, 2013), it also unleashed an unprecedented onslaught of racist comments directed at the asylum seekers, as well as racist and sexist comments directed towards anyone who appeared to support them (Falzon, 2016b; People for Change Foundation, 2013).

International Responses

Conflicts, civil war, a lack of recognition of human rights and violence, have been cited as the main reasons for the mobilisation of an unprecedented number of displaced people globally in 2015 (UNHCR, 2016d). Statistics related to the number of displaced people travelling to Europe in 2015 also showed more than a threefold increase when compared to the previous year (British Broadcasting Corporation (BBC), 2016). In consternation of these figures, a large number of EU member states have denied communal accountability (Human Rights Watch, 2016). Indeed, the response of the respective European governments was generally to introduce strategies that served to further strengthen the borders, irrespective of these countries being signatory to international agreements for the protection of refugees (Roth, 2016). Roth reported that this response was the result of a number of fears namely: a fear of the impact of refugees on their countries' societies, a fear emanating from the rise in terroristic activity and a fear of populist outcry (Roth). Numerous EU migration meetings and summits, including one held in Malta in November 2015, resulted in the formulation of a number of policies but, apart from the goals set not being achieved (BBC), these policies have been greatly criticized for their focus on curbing migration, as opposed to identifying strategies for the protection and welfare of the refugees (Caritas Europa (n.d.); Medecins Sans Frontieres (MSF), 2016; Popp, 2014; Roth; Trocaire, 2015). The protection of refugee and migrant rights, saving lives and responsibility sharing were the main issues addressed in a United Nations summit that was held in September 2016 and which culminated in the adoption of the New York Declaration for Refugees and Migrants by all the member states (United Nations, 2016). In their speeches, key officials at the summit optimistically verbalized the benefits that would arise out of the "bold commitments" (n.p.) that the member states were making in relation

to refugee rights and safety (United Nations) and nongovernmental humanitarian organisations also acknowledged the value of a high-level international meeting to address the unprecedented rise in “human displacement” (Refugee Solidarity Network, 2016, n.p.; Simmons, 2016; The Guardian, 2016). Notwithstanding this, the New York Declaration has been criticized by these same humanitarian organisations for the use of terminology that is too tempered and generalised (Bryant, 2006; Refugee Solidarity Network), for its failure to legally obligate the member states to address the stipulated commitments (Simmons; The Guardian) and for a lack of concrete plans that go beyond mere rhetoric to provide humane and effective international responses (Bryant).

The validity of the abovementioned criticism is accentuated when one considers how in November 2016 just one month following the adoption of the New York Declaration, the Maltese police rounded up and detained 32 asylum seekers from Mali who despite a rejected status and an expired THP-n permit had for several years been working and paying National Insurance and tax contributions on a three month renewable police permit (Carabott, 2016). Also in November 2016 and as mentioned in an above footnote, the Maltese government declared that all THP- n statuses that expired would not be renewed and that THP-n status would no longer be an official form of protection after 31st October, 2017 (Borg, 2016). Nongovernmental organisations and other entities criticised these two unexpected and unprecedented manoeuvres on both humanitarian and economic grounds and whilst the Maltese government claimed these developments were both legally justifiable (Borg), the inhumanity of uprooting, or threatening to uproot rejected asylum seekers who have been living and working in Malta for several years, is incongruent with a number of commitments outlined in the New York Declaration (United Nations, 2016).

As mentioned above, till June 2016, there has only been one family of two adults and three children, who landed on Malta by boat seeking asylum, out of a total of 786 asylum applications (UNHCR, 2016b), a far cry from the thousands of previous years. Additionally, whilst the prime minister of Malta initially appeared to have changed his position since his pushback threat in 2013 (Debono, 2015), this and other positive developments as previously highlighted, have been overshadowed by the re-emergence of a governmental discourse that link asylum seekers to illegality and security issues

(Micallef, 2016). This serves to fuel the xenophobia and racism specifically targeted towards asylum seekers that is still evident and that possibly emanates from international reports of terrorist activities (Dalli, 2016) and a conviction that there is no physical space for them, in view of Malta being “one of the most densely populated countries in the world” (Grech, 2015, n.p.).

Forced Migration, Health and Primary Health Care

The above account clearly highlights the challenges that asylum seekers in Malta face, in terms of both material and social deprivation, with them being constructed as the homogenous ‘Other’ (Pisani, 2013). Material and social deprivation have been found to impact negatively on asylum seekers’ physical and mental health, including healthcare access, healthcare provision and healthcare outcomes (Castaneda et al, 2015). Indeed, the recognition of the significance of socioeconomic conditions on health resulted in a Commission being launched in 2005 by World Health Organisation (WHO), with the aim of encouraging governments globally to address the social determinants of health and in so doing, minimise health inequities (WHO, n.d.). The Commission’s final report called for a national and international effort to collate the necessary evidence and provide adequate healthcare professional (HCP) training with regard to the social determinants of health which in collaboration with political goodwill and a change in socioeconomic policies, could reduce health inequities (Marmot, Friel, Bell, Houweling & Taylor, 2008).

The social determinants of health and PHC have been mooted as “related paradigms that prioritise health equity” because of the similarities in their expansive understanding of health and illness (Rasanathan, Montesinos, Matheson, Etienne & Evans, 2010, n.p.). Indeed, PHC is based on a broad definition of health, which demands that equal attention is paid to the health, social and economic sectors (WHO, 1978). In 1978, PHC was proposed as the ideal system to combat health inequities between and within countries (WHO) and with underlying principles such as universal healthcare access and a commitment to the attainment of social justice, PHC has become even more relevant in view of present day challenges, including globalisation (WHO, 2008).

Definitions of PHC are numerous, differ according to country and can be described by the functional, or philosophical attributes (Atun, 2004). Notwithstanding this, the characteristics common to all definitions are “first Contact Care; Accessibility; Comprehensiveness and Coordination of Care” (Muldoon, Hogg & Levitt, 2006, p 410). A healthcare system which gives importance to the PHC setting, has been found to be beneficial in relation to healthcare outcomes, service utilisation, patient satisfaction and equity (Atun, 2004). Moreover, it is a site that can serve to highlight existing inequities (Deka, 2012). It is in acknowledgment of this that the PHC setting has been chosen to carry out this study, which aims to explore asylum seeker healthcare access and utilisation and HCP provision. PHC in Malta is provided by the Ministry of Health as a free service and by private general practitioners, who charge for their services and who work independently to the government services (WHO, 2015). The present study solely addressed healthcare utilisation and provision in the government PHC sector.

Primary Health Care in Malta

PHC services in Malta are mainly provided through eight Health Centres scattered around the island and each of these Centres serve patients who reside in a specified catchment area, unless emergency care is required. Three Health Centres are open on a 24-hour basis, whilst the remaining five are closed at specific times, and in these instances their patients are directed to one of the main three for emergency care. All of the Health Centres provide main acute care services, namely GP walk-ins and nursing assistance and largely the same specialist services, with some exceptions. As the official Ministry of Health website states, similar to Maltese nationals and citizens of the European Union (EU), asylum seekers are entitled to all of the available services free of charge (Ministry of Health, n.d.).

Notwithstanding this, recently published entitlement guidelines stated that whilst refugees and asylum seekers under some form of protection are entitled to free healthcare services, the situation with regard to asylum seekers who are on a rejected status is not clearly specified in these guidelines, although in practice, these are also given the required care (Official, Health Care Funding, personal communication, 21st January, 2016). Asylum seekers who are unemployed are additionally entitled to all free medications available on the government formulary, although during my observation the doctors did not appear to

distinguish between employed and unemployed asylum seekers and would generally write their prescriptions on the free government prescription forms indiscriminately.

As mentioned above, the main Health Centres have a walk-in GP clinic on a 24-hour basis, with nights (from 20.00hrs – 08.00hrs), weekends (from Saturday 13.00hrs – Monday 08.00hrs) and Public Holidays reserved for emergency care. The GP services also provide home visits for those who are “too sick to be taken or walk to the health centre” (Ministry of Health, n.d., n.p.). There were a small number of the HCPs who reported that there was a union directive by the Medical Association of Malta (MAM), which stated that home visits to the Refugee Open Centres should not be carried out. That this directive truly exists was not confirmed by a union official, who said that more often than not the residents of the open centres did not fit into the strict criteria utilised for house calls, such as being elderly and bedridden (Official, MAM, personal communication, 30th June, 2016).

Nursing services at the health centres include any acute nursing treatment as required, as well as bloodletting services and wound clinics, which are both by appointment. Other specialist clinics are also by appointment and these include well baby and child immunisation clinics, diabetes clinic, gynaecological clinic that also provides antenatal and postnatal care, orthopaedic, physiotherapy, ophthalmic, glaucoma screening and podiatry clinics, amongst numerous others. Whether a referral is required or not is variable, with some of the clinics accepting self-referrals, such as the glaucoma and podiatry clinics and others, such as physiotherapy, requiring a referral from either a government-employed, or private GP. The way that appointments are made for the specialist clinics also varies according to the clinic, with some requiring that the patient makes an appointment at the reception desk of the relevant Health Centre, while with others requiring that the patients contact the specialist clinic directly on the specific day/s that this clinic is in attendance at the applicable Health Centre. This all signifies that patients need to be able to access the necessary detailed information, as well as have the resources and linguistic skills, if appointments are to be effected successfully.

When available, formal interpretation services are provided by cultural mediators. The cultural mediators who are employed with government healthcare services here in Malta

are generally themselves asylum seekers who are highly educated and who have undertaken a course run by the Migrant Health Liaison Office, specifically designed to provide cultural mediation within the healthcare sector (Migrant Health Liaison Office, n.d.). The high turnover that one finds in this occupation is due to the fact that these mediators are frequently chosen for resettlement, or because they are usually employed on a part-time basis only and thus leave the position if they find a full-time job elsewhere.

To date, cultural mediators have only been available in one of the Health Centres that has a catchment area which includes the main Open Centres accommodating the largest number of asylum seekers. Notwithstanding this and as previously outlined, asylum seeker trends to Malta have changed over the last three years, with the numbers of residents in the Open Centres constantly decreasing and with more asylum seekers living in the community (UNHCR Malta, n.d.). This means that whilst asylum seekers are accessing other Health Centres at an increasing rate, they are not provided with the interpretation services that are essential for effective and quality healthcare provision. Additionally, since 2012, the cultural mediator service in the above-mentioned health centre was only available sporadically, although the situation has now changed and since 2016 there have been two male cultural mediators employed at the health centre. One of these cultural mediators is from Somalia and is available five days weekly and another mediator, who is proficient in the Tigrinya and Amharic languages, is available once weekly (Migrant Health Liaison Office, n.d.). It is further relevant to note that despite an abundance of literature that illustrates the negative repercussions that gender discordant clinical encounters could have on the healthcare practices of female refugees (Morris, Popper, Rodwell, Brodine & Brouwer, 2009), all the cultural mediators providing their services in the PHC setting in Malta since 2012, have been male.

Justification for the Study

As mentioned above, pre- and post- migration factors have a potentially negative bearing on asylum seekers' health and healthcare practices. Indeed, the international literature is replete with evidence that shows inequities in, and barriers to, health and healthcare provision for minority ethnic groups and migrants (Jackson & Gracia, 2014; Malmusi,

Borrell & Benach, 2010; Randhawa, 2007; Schneider, Hoos & Bocorgmehr, 2015; WHO, 2010). There is additional literature which highlights that healthcare professionals (HCPs) also face difficulties when caring for these population groups (Kai et al, 2007; Priebe et al, 2011; Suphanchaimat, Kantmaturapoj, Putthasri & Prakongsai, 2015). Despite a dearth of similar studies carried out in Malta, findings from the few that have addressed varying aspects of asylum seekers' and HCPs' healthcare practices, point to the presence of numerous barriers that obstruct effective healthcare access and provision, including unclear entitlement policies, linguistic and cultural discordances and attitudinal issues (Camilleri & Zammit, 2012; Forman, 2012; HUMA Network, 2011; International Organization for Migration (IOM), 2013; Kopin & Integra Foundation, 2016; Luhman, Bouhenia & Giroux, 2007; Vjaters, 2014). The strong evidence of various difficulties in healthcare access and provision as provided by the international literature, coupled with the minimal studies that have been carried out in Malta despite the substantial increase in asylum seekers, strongly suggest the necessity for further studies to be carried out in this area.

Healthcare encounters are highly complex events, where interactions are shaped by both individual and collective influences within each specific context (Svenberg, Mattson & Lepp, 2013). Kilbourne, Switzer, Hyman, Crowley-Matroka and Fine (2006), stated that clinical encounters are a crucial juncture in the provision of equitable crosscultural health care and this is corroborated by Browne and Fiske (2001), who highlighted the benefits of studies that analyse health care encounters, arguing that this enables an understanding of the multiple underlying forces that influence crosscultural relations.

In acknowledgement of the above, the main aim of this thesis is to gain an insight into cross-cultural healthcare practices and provision through an exploration of clinical encounters between asylum seekers and HCPs in the PHC setting in Malta and further seeks to advance knowledge in:

1. The nature of cross-cultural healthcare encounters, with a focus on issues such as communication processes, relationship formation and information exchange.
2. Participants' experiences of cross-cultural clinical encounters in Malta.
3. The various factors that shape cross-cultural healthcare encounters in the Maltese PHC setting.

Terminology

The terminology used with people in circumstances of forced migration is highly variable and contentious (Ruz, 2015). The migrant participants in this study consisted of individuals on some form of temporary humanitarian status and others who had been rejected on appeal, or were waiting for a response to their appeal. Despite this, the term asylum seekers, which generally refers to individuals waiting for their asylum decision, will represent the participants of the present study throughout this thesis. This choice of terminology is based on a position that all these participants had a right to be in Malta and furthermore, in the belief that the social construction of the term asylum seekers has an impact on healthcare structures and healthcare encounters and could therefore be considered as a determinant of health in its own right. Despite using this one label, I would like to stress that I am not suggesting that the participants are one homogenous group, but that being an asylum seeker is a commonality amongst a highly heterogeneous group and which has a bearing on healthcare encounters.

Structure of the Thesis

This thesis consists of eight chapters, including this introductory one. Chapter Two presents a conceptual and empirical review of the conflicting debates around race, ethnicity and culture. It further describes the main cross-cultural healthcare approaches and system models and finally presents a selective critical review of studies that have explored healthcare encounters between migrants and HCPs in the PHC setting. Chapter Three presents the methodology and method used for this study. This chapter provides the rationale behind the utilisation of an ethnographic approach and a postcolonial stance. The research process is described in detail, as are the diverse ethical issues that arose throughout this process. Additionally, Chapter Three provides an overview of the Maltese PHC setting and presents pen portraits of the asylum seekers who participated in the interviews. Chapter Four, Five and Six present the findings through the three themes “Seeking Refuge and Beyond: The Migratory Process”; “Seeking Understanding: Communicating within the Healthcare Encounter”; “Seeking Resolution” and their respective sub-themes. Chapter Seven is a discussion of the findings analysed through a

postcolonial and intersectionality lens and presented through the candidacy framework. This combination has enabled the identification of a conceptual framework that illustrates the recursive cascades of influence that impact healthcare encounters, through the elements that they create. Chapter Eight concludes the study through an overview of the implications of the findings and related recommendations for research, practice and education.

Chapter 2: Asylum Seekers, Health and Healthcare - A Conceptual and Empirical Review

Introduction

Globalisation has resulted in a growing interest in cross-cultural healthcare practices, resulting in a proliferation of related literature and the development of various models that address cultural competence in healthcare provision (Balcazar, Suarez-Balcazar & Taylor-Ritzler, 2009), especially in the discipline of nursing (Norris & Allotey, 2008). Despite these endeavours, there is evidence that shows how health and healthcare disparities are still manifest amongst various migrants (Dixon-Woods et al, 2005; Jackson & Gracia, 2014; Malmusi, Borrell, Benach, 2010; Randhawa, 2007), including asylum seekers specifically (Schneider, Joos & Bozorgmehr, 2015).

In Malta, the few studies that have, to a varying extent, addressed issues related to asylum seekers and healthcare access, utilisation and provision, have all highlighted the presence of a substantial number of barriers to the acquisition of effective healthcare (Camilleri & Zammit, 2012; Forman, 2012; HUMA Network, 2011; International Organization for Migration (IOM), 2013; Kopin & Integra Foundation, 2016; Luhman, Bouhenia & Giroux, 2007; Vjaters, 2014). The results of these studies show that despite an increased need for healthcare services (Vjates, 2014), asylum seekers have difficulties to acquire the necessary information and furthermore, to make sense of unclear constitutional healthcare entitlements (HUMA Network, 2011; IOM, 2013). During cross-cultural clinical encounters, effective access is additionally hampered by linguistic and cultural discordance (Camilleri & Zammit, 2012; Forman, 2012; IOM, 2013), the latter of which is often based on stereotypically derived images and essentialised notions of culture.

An essentialised notion of culture is just one of the criticisms of cultural competency models (Engerbretson, Mahoney & Carlson, 2008; Owen & Randhawa, 2004), which were developed to counteract the above-mentioned health inequities (Betancourt, Green, Carrillo & Park, 2005) and which evolved from a transcultural nursing perspective introduced in the 1950s (Leininger, 1997). Another critique is that these competency models tend to

consider healthcare encounters as neutral and fail to acknowledge the divergent social positioning of migrants and HCPs and the impact of differential power, socio-economic status and oppressive structures on interactions and healthcare outcomes (Kirmayer, 2012). These limitations, amongst others, have led to a discourse in favour of a “critical culturalist approach to difference and healthcare practice” (Culley, 2006, p 144), with due consideration given to the definitions of the concepts of culture and ethnicity, to ensure that these provide a clear illustration of the complexities and versatilities of these concepts (Dorazio-Migliore, Migliore & Anderson, 2005).

This chapter aims to contextualise the present study within existing academic and theoretical debates and uses two specific reviewing methods to achieve this. First, an overview and discussion of key concepts drawn on in the thesis is provided. The literature presented here includes work from authors across a conceptual spectrum chosen to provide background and context to questions of migration, race, culture, ethnicity and health. This part of the chapter is therefore not designed to represent an overview of the whole field, which is beyond the scope of this thesis, but to specifically support the conceptual framing of this study.

In the second part of the chapter, a focused literature review of the specific work on cross-cultural encounters in PHC is presented. This literature was gathered via the ongoing collection and review of relevant materials since the outset of the study in 2010 via a number of methods including: database searches; reference chaining; publication alerts; conferences; and literature sharing with colleagues (Dixon-Woods et al, 2006). To allow for inclusion of studies outside of Malta and for those with conceptual or empirical salience for the present study, this strategy was devised to include international studies in a range of related fields and those studies with broader conceptual or empirical salience (see table 1). This was supplemented by an additional search in HyDi in August 2016, to identify any further recent publications.

Table 1 Inclusion and Exclusion Criteria

| Inclusion Criteria | Exclusion Criteria |
|---|---|
| Studies published in the English language | Studies not published in the English language |
| Studies carried out with migrants | Studies not carried out with migrants |
| Studies carried out in the PHC setting | Studies not carried out in the PHC setting |
| Studies addressing migrants' and HCPs' experiences of healthcare utilisation and provision | |
| Studies addressing migrants' and HCPs' practice in relation to healthcare utilisation and healthcare provision respectively | |
| Studies published from 2005 onwards | Studies published before 2005 |

HyDi is a one-stop search gateway available through the University of Malta Library that incorporates a wide range of search engines and networks including Academic Search Complete; Biomed Central; CINAHL Plus with Full text; ERIC; JSTOR; Journals @ Ovid full text; Medline/Pubmed; Social Science Research Network; PLoS; and Directory of Open Access Journals. The keywords utilised were drawn from the research question to ensure that these addressed the salient components: 'migrants', 'healthcare professionals', 'primary healthcare' and 'cross-cultural healthcare encounters' and the thesaurus tools available on mainstream databases were then utilized to identify related synonyms for each of these concepts. For example, this strategy helped identify alternative terms for 'migrants' such as 'immigrants', 'refugees', 'asylum seekers', 'displaced persons' and 'stateless persons' and these terms were then combined using the common Boolean operators 'OR', 'AND' and 'NOT'. Only one (unpublished) MSc dissertation which focused directly on migrant and primary healthcare in Malta (Forman, 2011 – 2012) was located and this study is discussed with the other results in part two of this chapter.

Race, Racialisation, Racism and Health

Race generally refers to the classification of groups based on genetic variations and by the beginning of the twentieth century this notion of race had developed into a credible and globally accepted scientific concept (El-Haj, 2007). Decades later, the discovery that the human race is genetically very similar with more variations found within 'racial groups' than across, resulted in the denunciation of race as a valid biological category by the majority of the scientific world. Indeed, results of a review that examined the use of race and ethnicity in the health literature, showed that ethnicity had greatly replaced race, especially in European publications (Afshari & Bhopal, 2010). Notwithstanding this, Ahmad and Bradby (2007) argued that despite a substantial and evident decrease in the use of race, many of the assumptions that underlie this concept are now manifest in the meanings assigned to ethnicity and culture. That these assumptions are still present in the twenty-first century is corroborated by Smedley & Smedley (2005), who further discussed how "physical traits have been transformed into markers or signifiers of social identity" (p 22), through racialisation.

Racialisation is the process by which individuals are categorised as 'Other' according to physical, or nationalistic attributes and are then placed within a hierarchical structure (Mulholland & Dyson, 2001). Bradby (2012) argued that evidence of racialization practices negates the notion of race as the unreal concept that it is and she further discussed the tangible reality of racism, with its negative consequences on health, healthcare utilisation and healthcare provision. Racism is the belief in the superiority of one race over another (Bhopal, 2007) and it has been argued that Malta's colonialist history has resulted in a denouncement of all things Arab, with the potential of racist thought governing attitudes towards the 'influx' of asylum seekers from Africa (Pisani, 2013).

A review by Ahmed, Mohammed & Williams (2007), that examined the influence of discrimination on health, showed how racism could lead to institutional discriminatory practices, as well as have an undesirable impact on individual interactions during healthcare encounters, with both resulting in health disparities. A qualitative study with refugees and other immigrants was carried out in Canada to examine their perceptions of discriminatory incidents during healthcare encounters. Over half of the participants

reported at least one experience of discrimination including HCPs passing stereotypical judgements in relation to language proficiency, physical appearance and nationality and the failure of HCPs to address their main concerns. These experiences impacted future healthcare behaviours and a few of the participants reported that following a discriminatory incident they refused to go back to the clinic, whilst others would only do so if an emergency arose (Pollock, Newbold, Lafreniere & Edge, 2012). A failure to consult a medical doctor when feeling unwell because of past experiences of being treated inappropriately was also evident amongst a few of the participants in a study carried out in Malta that examined asylum seekers' experiences of healthcare (Luhmann, Bouhenia & Giraux, 2007). In another Maltese study that explored migrants healthcare needs, one of the healthcare professionals said that whilst attitudes were changing, there were still a few healthcare providers who were racist (Forman, 2012).

The negative outcomes that arise out of discriminatory healthcare, perceived or otherwise, gives credence to the argument that racism is a social determinant of health (Griffith, Johnson, Ellis & Schulz, 2010) and despite social scientists' assertions that race is a social construct, the notion of race as a biological concept is still present in today's society (Bhopal, 2014), especially in the realm of genetics (Lee, 2009). This concept encourages the creation of divisor boundaries between the superior 'Us' and the 'Other' on the basis of physical characteristics (Durey, 2010) and Bhopal affirmed that in order to address these injustices the use of race in healthcare research should always be accompanied by a clarification of the underlying assumptions being made. This latter author further stated that the concepts of race and ethnicity are often utilised interchangeably, while Moubarac (2013) discussed the importance of exploring the "relationships between race, ethnicity and health" (p 104), if researchers are to avoid recreating essentialising discourses (Gunaratnam, 2003).

A lack of critical consideration to these issues in healthcare research is highlighted in two reviews, one that examined the use of race and ethnicity in a substantial number of primary studies published in a nursing journal (Drevdahl, Philips & Taylor, 2006), and another that reviewed the use of these two terms in epidemiological and public health journals (Moubarac). Results from both reviews showed that studies generally failed to provide

conceptual clarity, did not make any distinctions between the two concepts (Drevdahl et al; Moubarac) and in Moubarac's study, the majority of the reviewed literature utilised or constructed inappropriate racial categories.

Ethnicity, Ethnocentricity and Health

Whilst ethnicity has replaced race as a more acceptable term in the literature, it is a highly contentious concept and one that has attracted a century of critique (Phillips, 2007). The term ethnicity has been utilised excessively and accredited with a variety of diverse attributes (Ahmad & Bradby, 2007) and multiple interpretations (Yang, 2000).

Yang (2000) reported that one of the major differences in understandings of ethnicity is based on notions of whether ethnicity is inherited or constructed, known as primordialism and constructivism respectively. Notwithstanding this, Hale (2004) argued that there are very few proponents of the primordialist framework who ascribe to a genetic explanation, with Geertz asserting that whilst the genetic concept underlying the primordialist framework is unreal, society is deeply imbued with virtually permanent notions of clan and kinship that evoke specific behavioural responses (as cited in Hale, 2004, p 460). The undesirable consequences of a primordial, or essentialist understanding of ethnicity have been highlighted in the literature and include amongst others the reproduction of dominant hegemonic discourses that in turn guide policies (Hall, 1996); the assumption that 'whiteness' has no ethnicity ascribed to it and is the norm against which, the 'Other' is compared (Gunaratnam, 2003); the potential to foster ethnocentric views (Willis & Elmer, 2011) and the failure to acknowledge the impact of historical, political and socioeconomic forces on outcomes of power asymmetry and inequalities (Mulholland & Dyson, 2001). In relation to health issues, an essentialist approach to ethnicity has been found to have a direct impact on an individual's health and healthcare access in terms of both utilisation and provision, as stereotypical biologically assigned, or cultural traits, become the underlying cause of a medical condition (Ahmad & Bradby, 2007).

The sociological and anthropological literature, appears to favour a social constructionist understanding of ethnicity (Brubaker, 2006) and the underlying assumptions have

influenced the concept's development within a variety of movements such as post structuralism and post colonialism (Jenkins, 2008). A constructionist viewpoint is based on the belief that ethnicity is a dynamic process of identification, is constructed both individually and collectively and is relational to the context (Jenkins). This is in consonance with an understanding of the term ethnicity as one that "acknowledges the place of history, language and culture in the construction of subjectivity and identity, as well as the fact that all discourse is placed, positioned, situated, and all knowledge is contextual" (Hall, 1996, p447). The identification of ethnic categories is generally made by the dominant group creating symbolic boundaries, which when established, become social boundaries that reinforce the power asymmetries and generate further inequalities (Lamont & Molnar, 2002). In acknowledgement of this, Gunaratnam (2003) discussed the benefits of utilising a social constructionist framework when researching race and ethnicity because of its ability to uncover the impact of colonialism on racial and ethnic categories and the construction of boundaries that foster ethnocentric sentiments (Willis & Elmer, 2011).

The concept of ethnocentrism emerged at the turn of the twentieth century and was defined as "a view of things in which one's own group is the center of everything and all others are scaled and rated with reference to it" (Sumner, cited in Neulip, 2012, p 201).

Ethnocentrism is said to be ubiquitous and prompts behaviour across the boundaries towards the ethnic out-groups that have been categorised as such, based on conceptualisations of the constituents of ethnicity (Hammond & Axelrod, 2006). This is illustrated by the results of a study that explored the impact of ethnocentricity on people's perceptions of non-native accents and which showed how non-native accents significantly influenced perceptions of attractiveness on various levels in a negative way (Neuliep & Speten – Hamsen, 2013). The authors of a concept analysis of ethnocentricity presented various definitions pertaining to three main themes namely "group self-centredness", "outgoing negativity" and "ingoing positivity" and ultimately concluded that ethnocentricity is related to actions that confirm the in-groups' importance and superiority, with a Machiavellian approach to in-group preservation and members' interests (Bizumik & Duckitt, 2012, p 890).

There appears to be a dearth of recent research that has specifically explored the impact of ethnocentricity on health and healthcare outcomes and the older studies that are available are generally related to the nursing discipline. Notwithstanding this, there seems to be a general consensus of the negative impact that an ethnocentric perspective has on patient healthcare provision and outcomes (Capell, Dean & Veestra, 2008; Narayan, 2010; Sutherland, 2002). In an old but commonly cited article, Andrews (1992) listed the consequences of ethnocentric healthcare practices, which include ineffective patient- HCP relationships, misdiagnosis and unsatisfactory pain relief strategies. Unsatisfactory pain relief strategies were specifically highlighted by Narayan, who discussed how nurses were often unsuccessful in achieving adequate pain relief for their culturally diverse patients because of their failure to even contemplate that varied reactions to pain and varied responses to pain relief measures could be valid, and therefore deserved due consideration.

A quantitative study was carried out that aimed to measure the relationship between cultural competence and ethnocentrism, and despite the methodological limitation of a low response rate, evidence of an inverse relationship between the two variables points to a possible connection (Capell et al). Another quantitative study was carried out to examine the relationship between ethnocentricity, intercultural communication apprehension, uncertainty reduction and communication satisfaction on primary intercultural encounters. The findings showed how both ethnocentricity and intercultural apprehension had a negative impact on effective communication, as they encouraged avoidance strategies, which served to further increase feelings of uncertainty (Neulip, 2012). Although this study was not carried out in relation to healthcare professionals, or a healthcare setting, the results are highly relevant in view of evidence that shows how HCPs, similar to the rest of society, do have ethnocentric tendencies (Narayan) and do experience strong feelings of uncertainty and apprehension when involved in cross-cultural clinical encounters (Kai et al, 2007).

Hammond & Axelrod (2006) asserted that ethnocentricity leads to discriminatory action and this was corroborated by Sutherland (2002), whose concept analysis of ethnocentrism highlighted how prejudice, which arises out of an ethnocentric denial of the patients' beliefs, results in discriminatory practice and inequalities. Some of the studies presented in

the previous section illustrate the negative impact of discriminatory healthcare practices on healthcare outcomes and these findings, in addition to similar results that have emerged from the few studies that did directly address ethnocentricity, point to ethnocentricity as being a barrier to quality healthcare provision.

As can be seen from the above, ethnicity has been represented by a variety of models based on the associated conceptualisation, some of which fail to reflect ethnicity's complex, multidimensional and relational characteristics (Brubaker, 2006). Indeed, some of these models have been critiqued for their capacity to conjure images of cultural differences and deviances (Dein, 2006) and to render oppressive realities invisible (Hall, 1996). These and other concerns have also been directed towards culture (Phillips, 2007), as have assertions of the necessity to redefine traditional understandings of both ethnicity (Hall, 1996) and culture (Agar, 2006).

Culture, Culturalism and Health

In the mid-twentieth century, Kroeber & Kluckhohn (1952) published a highly significant review of over one hundred and fifty, often conflicting, definitions of culture, and a lack of consensus over this term is still evident in the twenty-first century (Atkinson, 2004). Jahoda (2012) critically examined the definitions that had been ascribed to culture in cross-cultural journals, published between 2009 and 2011. The variations amongst these were found to be substantial and at times contradictory, with the author concluding that an unequivocal definition can never be achieved and therefore, there needs to be an awareness of the diverse perspectives and their application.

Amidst these diverse understandings of culture, the contrasting essentialist and constructivist perspectives are the two main approaches that emerge in the health literature, with the essentialist viewpoint being the most evident (Blanchet Garneau & Pepin, 2015; Gray & Thomas, 2006), possibly because of its prominence in health education (Blanche Garneau & Pepin, 2015; Nazar, Kendall, Day & Nazar, 2014). The nature and quality of cross-cultural healthcare provision is greatly influenced by a clinician's understanding of culture, as it is this perspective that guides clinical practice (Dorazio-Migliore, Migliore &

Anderson, 2005) and healthcare research (Egede, 2006) and this has led to contestations of culture having the capacity to create both positive and negative practices (Napier et al, 2014).

An essentialist perspective of culture is guided by the positivist paradigm and has been defined as “the learned shared beliefs, values, and life ways of a designated or particular group which are generally transmitted intergenerationally and influence one’s thinking and action modes” (Leininger, 1995, p9). This definition gives an image of culture as being an objective and static phenomenon that guides people’s behaviours in a predetermined way (Gregg & Saha, 2006) and it is through this description that culture transpires into a health risk factor (Kao, Hsu & Clark, 2004). An essentialist perspective of culture categorises and labels groups of people based on socially constructed characteristics, which the dominant population presents as objective truths (Gray & Thomas, 2006). Through ‘Othering’ processes, these ‘cultural groups’ are then presented as a homogenous entity and differentiated from the superior majority population, who represent the norm (Vandenberg, 2010) in a reproduction of colonial injustices. In this way, cultural essentialism creates and sustains the dichotomy of ‘Western Culture’ and ‘Others’, based on narrowly defined and stereotypically derived categorisations and with no consideration given to historical, political and socioeconomic conditions (Browne, 2003). This has given rise to an increasing critique about culturist discourses and arguments against the utilisation of culturalist frameworks in healthcare practice (Johnson et al, 2004) and healthcare education (Culley, 1996; Nazar et al, 2014).

Culturalism has been defined as “the defence of distinct and essentialized communities in the name of the respect for differences” (Fassin & Rechtman, 2005, p348) and in healthcare it guides practitioners and researchers to utilise culturalist explanations for healthcare behaviours, experiences and outcomes (Willis & Elmer, 2011). The potential dangers associated with this outlook are highlighted in an article that presents a case study to demonstrate how a sole focus on culture could prevent clinicians from looking beyond their stereotyped notions to understand the lived reality of their patients, and in so doing, effectively respond to their needs (Kleinman and Benson 2006). These authors further discussed the problems of the utilisation of culturalist frameworks in healthcare because of

medicine's common understanding of culture as a list of traits, in conjunction with the conflation of culture with ethnicity, race and nationality, amongst others. This is corroborated in a study that utilised ethnographic methods to describe 'Othering' through an exploration of healthcare encounters between healthcare professionals and South Asian women (Johnson et al, 2004). The findings showed how 'Othering' practices were exhibited through essentialising, culturalist and racialised explanations that included: simplistic generalisations being made; culture being utilised as the sole explanatory model; culture being conflated with various behavioural and social attributes; a lack of awareness of the impact of power asymmetries on crosscultural interactions; and a failure to consider their patients' positionalities and the historical, political and socioeconomic forces that helped place them there (Johnson et al).

'Othering' practices are also highly evident in an article that in part discusses Maltese obstetricians' reactions and responses to caring for female asylum seekers who had undergone female genital cutting (Pisani, 2013). Furthermore, findings from a study carried out in Malta as part of a Sexual and Reproductive Health project, showed how a substantial number of the HCPs invariably applied culturalist explanations that were generally based on stereotypes and with no regard to broader potentially influential factors (Kopin & Integra Foundation, 2016). The ramifications of a culturalist approach to care increases in significance when, as illustrated in the previous chapter, the populist discourses around asylum seekers in Malta, as elsewhere, have been shaped by historical, political and socioeconomic forces. This is reinforced by Kleinman & Benson (2006), who stated that "culture is inseparable from economic, political, religious, psychological, and biological conditions" (p1674).

As can be seen from the above, an essentialist conceptualisation of culture does not only negate the dynamic and relational aspect of the phenomenon, but also impacts negatively on healthcare practices in its failure to enable HCPs to rise above stereotypical cultural assumptions of the 'Other' and acknowledge and address numerous salient issues (Williamson & Harrison, 2010). In cognisance of this, it has been argued that the adoption of a critical constructivist approach to culture is vital in its potential to uncover the

processes underlying the construction of the ‘Other’, fabricated by the dominant society to show who “we are not” (Gray & Thomas, 2006, p 79).

Lynam, Browne, Reimer Kirkham & Anderson (2007), give examples of situations that show how culture should be understood as both “dynamic and changing” (p 24) and additionally affirm the necessity of fostering critical discourses of constructivist concepts of culture that reflect its dynamic and social characteristics. A critical constructivist understanding of culture guides healthcare practitioners to view a person in a holistic manner, in recognition of historical, political and socioeconomic contexts (Lynam et al) and with an especial focus on power asymmetries (Browne et al, 2009). Gray and Thomas (2006) further attested that a critical constructivist approach would encourage practitioners and researchers to engage in critical reflection on the impact that conceptualisations of culture have and prompt activist action for equitable changes in healthcare policies and provision.

Cultures of Care

The two main perspectives of culture as discussed above, namely essentialist and critical, underpin a variety of clinical and educational healthcare models, as well as numerous research frameworks (Kumas-Tan, Beagan, Loppie, Macleod & Frank, 2007). These two main categories are generally divided into “culturally competent care”, which is based on an essentialist concept of culture and “cultural safety”, based on a constructivist model (Reitmanova, 2011). Culturally competent care (CCC) was originally devised by Madeleine Leinenger as an integral component of her Culture Care Diversity and Universality Theory (Leinenger, 2002), with models of CCC generally based on a general understanding of culture as static (Browne et al, 2009). Cultural safety models are based on a critical perspective that places an emphasis on crosscultural interactions and power asymmetries (Blanchet Garneau & Pepin, 2015).

Whilst there is evidence to show that the cultural context of healthcare had been a topic of study prior to the middle of the twentieth century (DeSantis & Lipson, 2007), it has been said that this literature was fragmented, involved studies that lacked a critical approach to their theoretical foundations and failed to provide any practical information for clinicians (Kleinman, 1980). In the 1950s Madeleine Leininger, a nurse and anthropologist, recognised the necessity of addressing this void, giving rise to a new discipline which she termed “transcultural nursing” (TN) (Leininger, 2002). Transcultural nursing has been defined as “a legitimate and formal area of study, research and practice, focused on culturally based care beliefs, values and practices” (Leininger, 2002, p 9) and which, Leininger claimed, has enabled nurses and other healthcare professionals to provide “culture-specific care” through its underlying theory (Leininger, 1999, p 9).

Leininger’s Culture Care Diversity and Universality Theory (CCDUT) originated from a theorising of the relationships between care and culture (Leininger, 2002), with an essentialist notion of culture as defined in the previous section. The Sunrise Model was created in conjunction with the CCDUT and Leininger (1999) asserted that when utilised together, nurses are provided with the necessary knowledge to actuate effective transcultural assessments and practice. With an increase in the influx of migrants to countries such as the United Kingdom, USA and Canada and other factors such as changes in immigration laws (McKenzie, 2008; Vandenberg, 2010), Leininger’s theory was opportune and prompted a growing interest in the topic. Indeed, the following decades bore witness to the development of a variety of cultural care models in both nursing (Shen, 2015) and other disciplines (Higginbottom et al, 2011), with many of these models based on the principles underlying CCDUT through the provision of culturally competent care (CCC) (Shen).

Despite an ever-growing interest in CCC, various authors have highlighted the lack of conceptual clarity surrounding this term, resulting in a lack of consensus in relation to both its definition, its assessment and the strategies to be utilised for its implementation within healthcare settings (Engerbretson et al, 2008; Eunyoung, 2004; Gallegos, Tindall &

Gallegos, 2008; George, Thornicroft & Dogra, 2015). Furthermore, as previously mentioned, a substantial number of these models are based on an essentialising concept of culture as defined by Leinenger cited above, resulting in the development of approaches that adopt a knowledge-based perspective (Engerbretson et al), with a potential to both create and substantiate stereotypical images (George et al). Dorazio-Migliore et al (2005) argued that essentialising and static conceptualisations of culture prevent healthcare professionals (HCPs) from looking beyond their preconceived, possibly incorrect notions of the culturally diverse patient standing before them, or to consider other influential factors at play during the clinical encounters. Furthermore, a 'cookbook approach' could result in culture being pathologised, with the patient's culture blamed for all ills (Ahmad & Bradby, 2008). A study carried out by Owens & Randhawa (2004) that explored professionals' crosscultural healthcare experiences in the provision of palliative care, argued that these healthcare providers utilised a self-critical approach and the nurses themselves concluded that competency models were over simplistic, especially in relation to the many complexities involved in community and domicile care provision.

Irrespective of the critiques of CCC as illustrated above, new models are continuously being created (Engerbretson et al, 2008; Rajaram & Blockrath, 2011) and CCC is still considered to have the potential to combat healthcare inequalities (Betancourt, Corbett & Bondaryk, 2014). Additionally, a review that examined the effects of culturally competent care showed positive health outcomes and wellbeing (Goode, Dunne & Bronheim, 2006), although findings from another study that looked at the impact of cultural competency on psychotherapeutic encounters with ethnic minorities were inconclusive (Huey, Tilley, Jones & Smith, 2014). Furthermore, despite CCC's theoretical origins, Blanchet Garneau & Pepin (2015), argued for the development of a model that could incorporate a modified version of cultural competence, within a cultural safety framework, which negates an essentialist view of culture.

Cultural Safety

Cultural safety, which is guided by critical social theory (Bourque Bearskin, 2011), was conceived to combat the inequalities in health and healthcare provision experienced by the

Maori population (Kirmayer, 2012) and was included in nurse and midwifery education in the early nineties (Papps & Ramsden, 1996). Cultural safety is rooted in a conceptualisation of culture that is broadly defined, with due consideration given to the impact of historical, political and socioeconomic conditions, as well as social categories such as age, gender and ethnic origin (Papps & Ramsden). Its primary focus is on the bicultural relationships between the HCP and the patient, with special consideration given to any differences that could have an impact on the patient's feelings of safety, or care provision (Crampton, Dowell, Parkin & Thompson, 2003). Furthermore, it is the patient who assesses the quality of the interaction, which encourages an examination of power imbalances within the relationship and beyond, and provides the means for these power imbalances to be redressed (Papps & Ramsden).

Whilst the concept of cultural safety in nursing has been mainly utilised in the branch of education (Blancet Garneau & Pepin, 2015; Crampton et al, 2003), Smye, Josewki & Kendall (2010) highlighted its benefits and uses across education, the clinical setting, at the policy making level and in research. This is corroborated in a research paper that explored the concept of cultural safety and its role in policy making in relation to aboriginal patients' health and wellbeing, with findings that show the advantages of adopting a culture safety framework at the policy level in view of the evidence of systemic discrimination (Brascoupe & Waters, 2009). Notwithstanding this, Reimer-Kirkham et al (2002) discussed this model's potential to reinforce essentialist conceptualisations of race, ethnicity and culture, as a consequence of its biculturalist approach. Furthermore, cultural safety has been critiqued for a lack of clarity (Gerlach, 2012) and a lack of evidence to show its effectiveness, in both the educational and clinical settings (Kirmayer, 2012).

Kirmayer (2012) attested to the impossible task of identifying a model of care that would be able to address all the complexities and variations associated with cross-cultural healthcare utilisation and provision, and there are numerous examples of researchers attempting to amalgamate models of care in an attempt to achieve this (Blanchet Garneau & Peppin, 2015; Carpenter-Song, Schwallie & Longhofer, 2007; Rajaram & Blockrath, 2011). Notwithstanding these efforts, healthcare inequities for migrants are still evident to this day (O'Donnell et al, 2016) and in view of the continuous rise of global migration,

especially in relation to people seeking asylum, further endeavours are urgently needed to address these disparities and discriminatory practices (Langlois, Haines, Tomson & Ghaffar, 2016).

Primary Healthcare Delivery Systems: Biomedical and Social Models of Care

Health systems are context specific, with healthcare provision and outcomes being highly influenced by societal conceptualisations of health and illness, which underpin the respective models of healthcare (Mazzotta, 2016). Indeed, it is the philosophical constructs that determine each model's uniqueness, through the way that they inform the respective health systems and in so doing, shape various aspects of healthcare provision (Harfield et al, 2015) and impact on equity to access (WHO, 2007).

The goals of PHC that aim to achieve “Health for All”, were identified at Alma Ata in 1978 and re-affirmed by the World Health Organisation (WHO) in 2008 (WHO, 2008). To reach these goals, a comprehensive model of care is required that goes beyond an understanding of biology as the sole origin of health and illness and that additionally acknowledges the significant role that socio-political and economic factors have on health and wellbeing (Labonte, Sanders, Packer & Schaay, 2014). Notwithstanding this and despite incongruence between the principles that lie at the cores of PHC and biomedicine, the majority of primary healthcare systems in the ‘Western’ world are generally shaped by a biomedical epistemology (Lapum, Chen, Peterson, Leung & Andrews, 2009).

A biomedical model of care is underpinned by the philosophical constructs of rationalism, positivism and structural-functionalism (Adibi, 2014) and it upholds a dualistic assumption, with an individualistic conceptualisation of health as “the absence of disease” and of illness as a physiological, or biological event which causes a dysfunction in the body (Warwick-Booth, Cross & Lowcock, 2012, p13). The utilisation of a biomedical model in ‘Western’ societies over the last century has resulted in immeasurable benefits in terms of scientific knowledge and medical advances. It is possibly because of this very success that to this present day, the biomedical model is still favoured over other models of care, despite an increasing recognition of biomedicine's failure to address the complex and

multidimensional processes that surround and impact on health and illness (Germov, 2014). Whilst acknowledging that there is a populist demand for healthcare delivery that embraces a biomedical model, Baum, Begin, Houweling & Taylor (2009) questioned the sustainability of this approach and further highlighted the resultant inequities that arise from a model of care, which fails to recognise the relationship between health and various structural forces. These limitations have led to the creation of diverse delivery models (Germov) and whilst the majority of these use individualistic conceptualisations of health and illness that tend to place responsibility solely on individual lifestyles, the social model acknowledges the multifactorial dimensions of health and illness and “places health fully in the dynamic interplay of social structures and embodied human agency” (Yuill, Crinson & Duncan, 2010, p11).

Social models of health originated from the main tenets of the declaration of Alma Ata and similar to PHC, uphold a social view of health that goes beyond biomedical explanations and draws attention to the broader factors that determine health status, collectively referred to as the social determinants of health (Talbot & Verrinder, 2010). These determinants have been defined as the social and material conditions that are shaped by a “wider set of forces and system structures” (WHO, n.d. n.p.) and which in turn, are directed by the prevailing political and economic discourses (Germov, 2014). There is irrefutable evidence that links marginalised, socioeconomically deprived communities with adverse health outcomes (Yuill et al, 2010) and the utilisation of a delivery system that addresses the broader determinants of health namely, a social model of care, has been commended as having the potential to reduce current, inequitable health outcomes (Talbot & Verrinder).

Migration has been cited as a social determinant of health because of the impact that immigration has on healthcare access in relation to entitlement and issues such as linguistic, social and cultural barriers (WHO, 2010). Indeed, in a landmark world conference on the social determinants of Health that was held in Brazil in 2011, migrants, especially those seeking asylum, were singled out as a population who face increased health risks because of diverse access limitations (International Organisation for Migration, n.d.). In acknowledgement of this, Lunn (2014) asserted that a delivery system based on a social model is especially warranted in healthcare provision for asylum seekers and

refugees, who generally face numerous living difficulties post-migration and are therefore, especially vulnerable to health disparities.

The benefits of addressing the broader determinants of health in this population has been illustrated in a qualitative study carried out by Sixsmith, Lawthom, Maintian, Whittle & Fang (2012), who examined healthcare access of Somali and Iraqi asylum seekers and refugees in the UK. The findings showed how these migrants experience various living difficulties on their arrival in the UK and how, the general practitioners' lack of interest in their socio-medical history, resulted in feelings of mistrust in the diagnosis made and the ensuing prescription. A holistic view of health was also evident amongst Somali immigrant women in another study carried out in the USA, with resultant expectations of personalised doctor- patient relationships (Pavlish, Noor & Brandt, 2010). However, these women further felt that the doctors generally asked far too many questions and ordered too many investigations prior to prescribing any treatment. They reported that this was unlike their previous experiences in Somalia, where following an explanation of their symptoms, the HCP would immediately administer treatment, often in the form of an injection (Pavlish et al). Indeed, a report for UNICEF compiled by Mazzilli & Davis (2009) who examined healthcare seeking behaviour in Somalia, described how medications are often acquired directly from private pharmacies, without the need of a prescription. Drawing on the findings of ethnographic research carried out in Ethiopia, Carruth (2014) confirmed that there was a high demand for medication, especially antibiotics, among the communities under study. This author further claimed that this was a consequence of the population's encounters with episodic humanitarian programmes, resulting in a hybrid of 'traditional' and 'western' medicine.

Asylum seekers are a highly heterogeneous group with different health beliefs and healthcare experiences, which distinctively shape their healthcare expectations that in turn, raises the need for sensitive responses through complementary healthcare approaches (Asgary, Charpentier & Burnett, 2013). So whilst the benefits of utilising a social model of healthcare delivery cannot be negated (Baum et al, 2009; Germov, 2014; Harfield et al, 2015; International Organisation for Migration, n.d; Talbot & Verrinder, 2010; WHO, 2010; Yuill et al, 2010), especially amongst asylum seekers (International Organisation for

Migration, n.d.; Lunn, 2014), it is essential to additionally ensure that the healthcare model utilised is comprehensive and fosters a pluralistic approach that would enable asylum seekers to access care in a “safe, respectful, cost-efficient and effective manner” (WHO, 2013, p7).

Healthcare access of minority ethnic groups is determined by a variety of factors that can be detected at the system level, as well as during clinical encounters (Guilfoyle, Kelly & St Pierre-Hansen, 2008). Betancourt, Green & Carillo (2000) affirmed that the nature and subsequent outcomes of clinical encounters are influenced by diverse situations and characteristics that impact on the development of therapeutic cross-cultural professional - patient relationships. Furthermore, healthcare encounters have been cited as a location where historical and socio-political forces of oppression are recreated (Pesut & Reimer-Kirkham, 2010) and when studied through a critical lens these forces are revealed, as is their impact on the interactions within cross-cultural healthcare encounters (Browne, 2007).

Cross-Cultural Healthcare Encounters: Migrants in the Primary Healthcare Setting

This section provides an overview of the research findings in relation to healthcare encounters between migrants and HCPs in the primary healthcare (PHC) setting, which is the specific focus of this study. The aim of this section is to produce a selective review that enables an examination of the findings from recent and relevant studies, which in addition to the conceptual considerations discussed above, have guided the focus of the present research study.

Teal & Street (2009) reported that in medical encounters HCPs should aim to achieve three goals namely, the development of a therapeutic relationship, the gathering of the information necessary to enable an evaluation of the patient problems and needs, and lastly, addressing the patient’s problems and needs effectively. The following review will be presented through these three goals.

Goal 1: Developing therapeutic relationships

The development of therapeutic relationships in healthcare is key to achieving satisfactory outcomes (Moll, Frolic & Key, 2015) and both the nursing and medical literature cite trust as one of the most important components of these relationships (Dinc & Gastmans, 2013; Rowe & Calnan, 2006). Various studies have shown trust to be a major issue amongst asylum seekers and refugees specifically (Asgary & Segar, 2011; Fang, Sixsmith, Lawthom, Mountian & Shahrin, 2015; Feldman, Bensing, Ruijter & Boeije, 2007; Jonzon, Lindkvist & Johansson, 2015; Lawrence & Kearns, 2005; Mann & Fazil, 2006), not least as a result of international political and populist discourses of asylum seekers and refugees as the “helpless, burdensome other” (Moreo & Lentin, 2010; Olsen, El-Bialy, Mckelvie, Rauman & Brunger, 2016). This was evidenced by a qualitative study that utilised focus groups and one-to-one interviews with asylum seekers, refugees and healthcare providers, to explore their perceptions of the barriers to healthcare access (Glasgow Centre for Population Health (GCPH), 2008). Results showed how asylum seekers’ and refugees’ encounters with HCPs were determined by how their experiences of populist discourses surrounding the terms ‘asylum seekers’ and ‘refugees’ had impacted on their expectations.

Current asylum debates generally construct asylum seekers and refugees as dependent and a burden on the host country, with them often being blamed for social service insufficiencies (Moreo & Lentin, 2010). Furthermore, these discourses influence the power differentials within interactions between HCPs and the ‘Other’ (Ghorashi, 2005). A study in the United Kingdom (UK) carried out a media analysis of migration discourse in selected UK newspapers and followed this by individual interviews with asylum seekers, refugees and HCPs to explore the impact of this discourse on their perceptions of deservingness and healthcare. Results showed how negative constructions are internalised by migrants, which in turn influence their interactions with healthcare services (Matthews, Burns, Mair & O’Donnell, 2016).

Refugees’ and asylum seekers’ internalised notions of both being perceived as, and being, an undesirable burden, discourages them from accessing healthcare services unless deemed absolutely necessary (Cheng, Drillich & Schattner, 2015). These internalised notions also

impact on their level of trust in HCPs (Feldman et al, 2007), further compounded by incongruent expectations and understandings of health and illness (Lawrence & Kearns, 2005). Results from a number of studies show how migrant expectations are often linked to past healthcare experiences in their country of origin and examples of this are mainly provided through migrants' accounts of general practitioners' reluctance to prescribe antibiotics and what they, the migrants, perceive to be unnecessary tests and investigations, as opposed to receiving an immediate diagnosis and treatment (Boateng, Nicolaou, Dijkshoorn, Stronks & Agyemang, 2012; Lawrence & Kearns, 2005; Pavlish, Noor & Brandt, 2010).

Another issue raised by asylum seekers and refugees which impacted negatively on their trust of HCPs and the development of therapeutic relationships, was what they viewed as the common and unjustified practice of general practitioners claiming that their unexplained symptoms were psychologically induced because of their past traumatic experiences (Asgary & Segar, 2011; Cheng et al, 2015; Feldman et al, 2007). Indeed, a study that aimed to explore the first diagnosis given to female asylum seekers, who were then eventually diagnosed with hypovitaminosis D, showed that 90% of these patients were initially diagnosed with some form of somatisation disorders and the mean duration from first medical visit to the real diagnosis was of 1.87 years (de La Jara, 2006). Notwithstanding this, findings from a systematic review and meta-analysis that reviewed 181 surveys carried out in over 40 countries, showed that refugees and post-conflict populations had a higher prevalence rate of post-traumatic stress disorder and depression globally (Steel et al, 2009), with both of these conditions showing an association with somatisation (Gupta, 2013; Lowe et al, 2008). Another literature review additionally highlighted somatic complaints as one of the main psychological conditions suffered by refugees and asylum seekers as a consequence of past torture (McCulley, 2014), whilst a quantitative study carried out by Laban, Gernaat, van der Tweel & De Jong (2005) showed how postsettlement problems, especially those related to family, asylum procedures and work, are also linked to mental health issues including somatoform disorders.

The general practitioners (GPs) in Feldman et al's (2007) study, which focused specifically on medically unexplained symptoms (MUPs), reported that MUPs were highly prevalent

amongst refugees and that these resulted in a substantial number of referrals to other professionals working in social and mental health services. Trainee GPs participating in another study, which aimed to explore their experiences of healthcare provision to Somali refugees, reported that these patients focused mainly on physical symptoms and generally refuted the GPs' suggestions that the underlying cause could be psychological (Svenberg et al, 2013). Perron & Hudelson (2006) interviewed 26 asylum seekers and refugees from former Yugoslavia, who had been diagnosed as somatisers by their doctors. Results showed that whilst the participants established a link between their physical symptoms and past and present migratory experiences, they still expected these symptoms to be treated medically. Mayou, Kirmayer, Simon, Kroenke & Sharpe (2005) argued that the term somatoform disorders is irrelevant to people whose cultures have diverse views of the mind body dichotomy and furthermore, it is a diagnosis that appears to question the legitimacy of the patient's claims. This could possibly explain asylum seekers' and refugees' reports of discriminatory healthcare practices from what they perceive to be HCPs' responses to the stereotypes and stigma associated with the labels of "asylum seeker" and "refugee" (Asgary & Segar, 2011; Bhatia & Wallace, 2007; Cheng et al, 2015; Fang et al, 2015; Feldman et al, 2007; O'Donnell, Higgins, Chauchan & Mullen, 2007).

Various studies have reported positive outcomes in terms of trust and migrant satisfaction, when GPs and other HCPs show an interest in migrants beyond their physical symptoms (Carroll et al, 2007; Cheng et al, 2015; Feldman et al, 2007; Paternotte, van Dulmen, van der Lee, Scherpbier & Scheele, 2015), listen carefully and acknowledge what the migrant has to say (Asgary & Segar, 2011; Cheng et al, 2015) and allot appropriate time to the encounter (Asgary & Segar, 2011; Pavlish et al, 2010). A patient-centred approach incorporates these behaviours and findings from a study that aimed to identify communication strategies used by GPs with migrants, showed that a patient-centred approach is generally utilised (Rosenberg, Kirmayer, Xenocostas, Dominice Dao & Loignon, 2007) and has further been found to be beneficial to crosscultural healthcare communication and provision (Saha, Beach & Cooper, 2008). Another study focused on the way that GPs' understood and managed their encounters with migrants, and the findings also demonstrated an individualised approach to care, which the authors attested

enabled the doctors to attain an understanding of migrants' explanatory models of health, illness and treatment (Wachtler, Brorsson & Troein, 2006).

Despite these findings and despite a substantial number of migrants generally expressing positive views about healthcare in the host country (O'Donnell, 2007), these participants also reported interactions which they described as rushed, with HCPs' who did not show any interest in them (Asgary & Segar, 2011; Feldman, Bensing, Ruijter & Boeijs, 2006; Pavlish et al, 2010; Svenberg et al, 2011) and who were culturally insensitive (Fang et al, 2015; Pollock et al, 2012). Cultural differences have been cited as a major challenge by HCPs (McKeary & Newbold, 2010; Kalengayi, Hurtig, Ahlm & Ahlberg, 2012; Priebe et al, 2011; Wahoush, 2013) and have been found to result in "professional uncertainty" of appropriate communication strategies and the approaches to be utilised within crosscultural healthcare encounters (Kai et al, 2007, p1768). These latter authors further assert that this uncertainty results in HCPs' resorting to essentialising practices and experiencing feelings of helplessness, which in turn compromise the development of therapeutic relationships. These findings strengthen Napier et al's (2014) call for a renewed focus on culture in healthcare practice, based on a redefinition of culture that acknowledges that:

Culture is key to the practices and behaviours of organisational structures and professions, including the health professions; the health priorities of individual, groups and systems of health delivery; and the practices of professionals that bring together or alienate givers and receivers of care. (p. 1630).

These authors further asserted that this redefinition would enable an exploration of the prejudices inherent in a biomedical approach to care (Napier et al, 2014) and the pervasive ways that this approach subconsciously influences HCPs' healthcare practices (Lee, 2009).

As outlined in a previous section, the biomedical model of care has been utilised for over a century and despite various criticisms targeted at this approach over the years (Engel, 1977; Kleinman, Eisenberg & Good, 1978; Putsch & Joyce, 1990, Wade, 2009), it is currently still in use (Wade). The biomedical approach has been cited as a model that reflects a 'Westernised' understanding of illness (Shah & Mountain, 2007) and is based on

the view that pathology is the sole cause of disease (Wade & Halligan, 2004), a view which Engels (1977) asserted exonerates doctors from addressing their patients' psychosocial needs. In the past, the biomedical model has been instrumental in the successful management of previously fatally infectious diseases (Bennett Johnson, 2012), but both Kleinman et al (1978) and Putsch and Joyce (1990) affirmed that there is a gap between biomedicine's pathological definition of disease and lay peoples' experiences of their illnesses, which expands substantially in cross-cultural situations (Putsch & Joyce, 1990).

Results from a study that utilised focus groups and interviews with Somali immigrant women, a small number of whom were HCPs, showed how misunderstandings within healthcare encounters would occur because of contrasting health beliefs (Pavlish et al, 2010). The participants of this study held a holistic view of health that was influenced by their situational context and which was at variance with the biomedical approach that they encountered, resulting in unfulfilled expectations. Divergent understandings of health, illness and healthcare between refugees and the HCPs and the healthcare system in the refugees' host country were also evident in another qualitative study and the results further showed how these participants' views of health and wellbeing went far beyond a biological definition of health and illness, as conceptualised by a biomedical model (Lawrence & Kearns, 2005). This is corroborated by the findings from other studies that do not only show migrants' lack of trust in HCPs because of discordant expectations (MacFarlane et al, 2009; Pollock et al, 2012), but further illustrate the impact of pre-migration and post-migration circumstances on migrants' health, their definitions of health and illness and their experiences of health care encounters (Fang et al, 2015; Gilgen et al, 2005). Indeed, the importance of HCPs' gathering the necessary information with regard to their patients' worldviews has been highlighted (Juckett, 2005), as has the necessity of HCPS' eliciting psychosocial issues that are relevant to the refugee in addition to his/her presenting medical complaint (Kleinman & Benson, 2006).

Goal 2: Gathering Information and Assessment of Needs

An HCP's ability to gather the required information that would enable a correct diagnosis, or an accurate assessment of patients' needs, has been identified as essential in both the medical and nursing literature (Fong Ha & Longnecker, 2010; Fennessey & Wittmann – Price, 2011). This ability has been attributed to the HCPs' communication and interpersonal skills (Fong Ha & Longnecker, McKenna, Innes, French, Streitberg & Gilmour, 2011), which when proficient, provides for a superior comprehension of the patients' problems and their priorities of care (Fawcett & Rhynas, 2012). Each individual generally forms part of a variety of micro-cultures concurrently and therefore, each healthcare interaction is intercultural and should be acknowledged as such, through attention being paid to the cultural context (Neuliep, 2012). This possibly holds even more relevance in cross-cultural healthcare encounters, and a European review of HCPs' good practices in migrant health referred to overcoming cultural obstacles through consideration being given to the impact of both the migrant's and one's own culture (Mladovsky, Ingleby, McKee & Rechel, 2012). The biomedical model of care has also been referred to as a culture (Kleinman & Benson, 2006), or sub-culture (Putsch & Joyce, 1990) and therefore its impact on encounters should also be examined, especially in view of its narrow definition of disease and how this influences the gathering of important patient information (Fong Ha & Longnecker).

“Cultural skills” is one of five constructs in a model of cultural competence and refers to a HCP's ability to gather the required information, including the pertinent cultural content (Campinha – Bacote, 2011, n.p.). In view of the heterogeneity of all ethnic and cultural ‘groups’, Kleinman & Benson (2006) emphasised the importance of using an approach that would enable the HCP to understand each individual patient's worldview and priorities, and avoid common stereotypes. Cultural and linguistic discordance are interconnected factors, with language cited as a major barrier for GPs when attempting to elicit their patients' needs (Harmsen, Bernsen, Bruijnzeels & Meeuwesen, 2008), or when delivering a diagnosis and trying to provide further information and advice (Wilkinson et al, 2011). In all of the studies reviewed, language discordance has been highlighted as one of the major barriers to effective healthcare encounters, from the perspectives of both migrants and

HCPs (Asgary & Segar, 2011; Bachmann, Volkner, Bosner & Donner-Banzhoff, 2014; Bhatia & Wallace, 2007; Boateng et al, 2012; Cheng et al, 2015; Dastjerdi, Olson & Ogilvie, 2012; Dauvrin et al, 2012; Fang et al, 2015; GCPH, 2008; Jonzon et al, 2015; Lawrence & Kearns, 2005; McKeary & Newbold, 2010; Paternotte et al, 2015; Pithara, Zembylas & Theodorou, 2012; Priebe et al, 2011; Suphanchaimat et al, 2015; Svenberg et al (2013); Wahoush, 2013; Wang & Kwak, 2015; Kalengayi et al, 2012). This is further corroborated by findings from a critical interpretive review that reported how illiteracy in English would result in difficulties for migrants throughout the various stages of the healthcare pathway, including a reluctance on the migrants' part to seek medical help (Dixon-Woods et al, 2005).

The situation appears to be similar in Malta and a report by PICUM (2010) that addressed the needs and strategies of undocumented migrants to healthcare access in 17 EU countries claimed that a major obstacle to healthcare access in Malta was migrants' fear of miscommunication as a result of linguistic and cultural barriers. Findings from a study by Forman (2012) that utilised interviews with migrants and healthcare professionals to explore the literacy, culture and language need of migrants, appeared to justify these fears and the results showed how a lack of linguistic and cultural understanding impacts negatively on effectiveness of health care provision in Malta.

The results of a study carried out in Germany aimed at comparing the experiences of primary care encounters between Russian speaking migrants and Germans, showed that language-related problems were uppermost, especially in relation to the migrants being concerned about their inability to describe their symptoms clearly (Bachmann et al, 2014). In another study that aimed to explore immigrants' and refugees' perceptions of discrimination in Canadian health care, some of the participants reported that even when there was some understanding of English, the anxiety experienced during the encounter, could result in linguistic misunderstandings (Pollock et al, 2012). A systematic review that explored HCPs' perceptions of their interactions with migrants showed how challenges due to language barriers were raised in the majority of the studies reviewed and furthermore, how the barriers resulted in communication being solely restricted to addressing the

migrants' physical complaints, to the detriment of other important issues which remained unresolved (Suphanchaimat et al, 2015).

Despite a growing recognition of the problems associated with the use of informal interpreters in healthcare, this practice is still extensive (Leanza, Boivin & Rosenberg, 2010). Results from a study with 453 HCPs showed that over half of these attested that they often utilise family and friends to aid in their interactions with linguistically discordant patients (Kale & Syed, 2010). Despite this regular use of informal interpreters, HCPs find the practice challenging for many reasons: the interpreter's omission to translate all the information and instances of miscommunication (Zendedel, Schouten, van Weert & van den Putte, 2015), the possibility of interpreters pushing their own agenda (Leanza et al; Rosenberg, Leanza & Seller, 2007), their lack of knowledge in relation to medical terminology (Rosenberg et al) and possibilities of patients being uncomfortable and uncertain regarding confidentiality issues (MacFarlane et al, 2009). Additionally, a study that examined videotapes of encounters between Turkish migrants and GPs, both with and without informal interpreters, showed that the migrants demonstrated fewer emotional cues in the presence of the informal interpreter (Schouten & Schinkel, 2014). Notwithstanding these potential complications, Kale & Syed's previously mentioned study found that in situations of linguistic discordance, HCPs would choose what they viewed to be the easiest option, including the use of informal interpreters, trying to get by without any help and only using professional interpreters intermittently.

A systematic review found that the use of formal interpreters positively influenced migrants' quality of care on four counts namely: "communication, utilisation, clinical outcomes and satisfaction with care" (Karliner, Jacobs, Chen & Mutha, 2007, p 727). Despite this and as mentioned above, doctors often avoided using professional interpreters, with issues related to trust, control and power, highlighted as three major difficulties encountered in a triadic healthcare encounter (Brisset, Leanza & Laforest, 2013). This is corroborated by Hsieh's (2010) qualitative study, with results that illustrate how both healthcare providers and professional interpreters struggle to control the interactive process, and how these conflicts could be addressed through training and an organisational culture that promotes multidisciplinary collaboration. The necessity for HCP education in

relation to working with professional interpreters is evidenced in findings that show how a large number of HCPs are not cognisant of the professional interpreters' role and furthermore, reported a lack of satisfaction in the paucity of training related to the use of interpreters within their organisation (Kale & Syed, 2010). This strongly supports Mladovsky et al's (2012) assertions that organisations have an important role to play in ensuring quality care to migrants, with due attention being paid to the organisational ethos, environmental factors and the provision of educational opportunities.

Goal 3: Addressing the Patients' Problems and Needs Effectively

In addition to the difficulties that linguistic discordance has on gathering information, it has also been found to have a negative impact on the patient's ability to understand the medical situation and prescribed medication (Wilson, Chen, Grumbach, Wang & Fernandez, 2005). A study was carried out in the UK to explore medicine-related problems among South Asian and Middle Eastern migrants and language discordance was identified as one of the contributory factors to non-adherence of prescribed treatments, mainly because the patient did not have the necessary information (Alhomoud, Dhillon, Aslanpour & Smith, 2015). In another study that focused on Pakistani immigrants in Norway, a lack of language proficiency was also found to be influential on incorrect medication usage (Hakonsen & Toverud, 2012). This lack has also been found to impact negatively on migrants' receipt of preventive care and has been identified as a factor that plays a role in migrants' vulnerability, further highlighting the need for the provision of interpreter services (Pitkin Derose, Escarce & Lurie, 2007). In the above-mentioned two studies, cultural factors were also found to play a major role in medication usage, with a substantial number of migrants who were Muslims, modifying the prescribed intake of medications in Ramadan (Alhomoud et al; Hakonsen & Toverud).

Divergent expectations between the patient and the HCP have also been found to influence migrants' adherence to health-related advice and prescribed medication (Anderson, 2008) and as mentioned previously, some migrants were dissatisfied with the outcome of the encounter because of doctors' reluctance to prescribe antibiotics (Boateng et al, 2012; Pavlish et al, 2010; Svenberg et al, 2011). In addition to medication, the Somali refugees

who participated in Svenberg et al's Swedish study also expected the doctors to provide them with information about their illness and felt that their needs were not being met, specifically because they were Somali immigrants. As a result of this, a number of these migrants would borrow money from family or friends to go to Germany for treatment. Transnational practices were also evident in a Canadian study with Korean immigrants, who were dissatisfied with the long waiting lists and with the standards of care provision. As a result all the participants had sought medical help from South Korea in some form or other (Wang & Kwak, 2015).

A good patient – HCP relationship is essential at all stages of the healthcare encounter and not least in the decision making process where the HCP is required “to operate with the utmost awareness and adaptability to negotiate a shared understanding with the patient and to reach agreement on how the patient's symptoms will be prioritized, diagnosed and treated” (Teal & Street, 2009, p 540). Shared decision-making is increasingly gaining prominence as a suitable strategy, wherein the patient and HCP jointly take a decision on the preferred treatment option (Elwyn et al, 2012). Notwithstanding this, a literature review that explored shared decision-making within a cross-cultural context identified four barriers, three of which have been discussed above namely, linguistic discordance, divergent understandings of health and illness and divergent expectations (Suurmond & Seeleman, 2006). The fourth barrier refers to the prejudices that the patient and/or HCP might harbour and the impact of this on their interactions.

Prejudice has been defined as an unfounded antagonism towards a group, or a member of that group (Phelan, Link & Dovidio, 2008) and HCP prejudice has been cited as one of the main sources of health disparities which arise out of healthcare encounters (Balsa & McGuire, 2003) and that can result in discrimination (Stuber, Meyer & Link, 2008). Prejudice, which compounds social inequities and exclusion, is shaped by historical forces within a socioeconomic and political context (Dovidio, 2001; Parker, 2012). Social exclusion is a “dynamic, multi-dimensional process driven by unequal power relations” and with processes that “operate along and interact across four main dimensions – economic, political, social and cultural” (Popay et al, 2008, p 7). Marginalisation exposes these migrants to healthcare disparities in health policies that restrict healthcare

entitlements and healthcare access (O'Donnell et al, 2016). Indeed, despite increased challenges and a high burden of disease, migrants, especially asylum seekers, face restricted healthcare services in a substantial number of European countries and in some cases, undocumented migrants do not even have access to emergency care (Rechel et al, 2011).

Conclusion

The above overview discussed the findings of selected studies of the three main goals of healthcare encounters in the PHC setting as identified by Teal and Street (2009). This has led to an illustration of the complexity of cross-cultural healthcare encounters, with findings that reveal various intersecting elements. These elements include trust issues, the impact of social constructions of the terms “asylum seeker” and “refugee”, divergent expectations; divergent explanations of health and illness, the impact of a biomedical culture, linguistic discordance, prejudice and discrimination. It is pertinent to note that the majority of the studies under review did not utilise a critical perspective to guide their research and therefore the invisible processes underlying and shaping these elements, have not been explored. Additionally, the lack of a critical approach with its resultant essentialist position serves to emphasise the differences and distance between ‘Us’ and the ‘Other’ (Reimer Kirkham, 2002) and fails to acknowledge the impact that past and present events and discourses have on conceptualisations of race and culture and in turn, on health and healthcare disparities (Anderson, 2004).

Postcolonialism is one of a variety of approaches that utilises a critical constructivist position and has been identified as an ideal lens to examine health inequities through an acknowledgement of the impact that a past history of colonialism has on healthcare interactions and outcomes (Beavis et al, 2015). Its value lies in the ability to draw attention to essentialising discourses associated with race and culture and the power asymmetries embedded within these discourses, which have been shaped through an ongoing “colonizing process” (Anderson, 2004, p 240). Analysis through a postcolonial perspective draws attention to social and health inequities and in so doing, helps accentuate discriminatory institutional policies and healthcare practices (Browne, Smye & Varcoe,

2005), as well as highlight the negative impact that these have on the experiences of marginalised populations throughout the healthcare pathway (Anderson). Reimer Kirkham et al (2002) asserted that “processes of colonialism and marginalization cross geographical and political boundaries” (p 226) and that critical models are applicable to all “racialized immigrant groups” (p 227). Despite this and the above-mentioned benefits of utilising a postcolonial approach to migrant health research, the studies that have explored various aspects of healthcare access, utilisation and provision through a postcolonial lens, have mainly been carried out with indigenous populations.

Additionally, the analysis of an above-mentioned interpretive review that explored healthcare access in relation to ethnic minorities amongst other vulnerable populations concluded that the majority of the studies failed to acknowledge the diversity “within as well as between groups” (Dixon-Woods et al, 2005, p 127). This observation is especially pertinent in view of Randhawa’s (2007) assertions that healthcare inequalities are multidimensional and therefore the impact of these factors including the social determinants of health, should invariably be acknowledged and addressed. de Leeuw and Greenwood (2011) discussed the benefits of applying an intersectionality lens when examining health and healthcare issues through the determinants of health, with colonialism included as one of the determinants.

Intersectionality is a paradigm which, similarly to postcolonial theory, ascribes to the tenets of critical constructivism and has been cited as a suitable lens to examine the way that an individual’s multiple identities are constructed and intersect within power discordant relationships to ultimately shape experiences (Van Herk, Smith & Andrew, 2011). Asylum seekers are a highly heterogeneous group with each individual having diverse statuses, which produce distinctive intersecting oppressions and distinct experiences, and the utilisation of an intersectionality approach enables the researcher to go beyond essentialist explanations and explore these distinct oppressions (Dhamoon & Hankivsky, 2011). Notwithstanding this, acculturalist models are still reported to be ones that are most commonly utilised to guide cross-cultural healthcare studies, despite the limitations that the underlying concept of these models place on exposing the impact of the broader determinants of health, some of which are of extreme relevance to migrant health

(Viruell-Fuentes, Miranda & Abdulrahim, 2012). These latter authors further bemoaned the scarcity of migrant healthcare research that utilises an intersectionality lens to enable inequitable structures and policies to be brought to light, which they claimed is especially pertinent in the present day climate of anti-migrant sentiments (Viruell-Fuentes et al).

As mentioned previously, there has only been one small study carried out in Malta that partially addressed asylum seeker healthcare utilisation and provision in the Primary Healthcare setting (Forman, 2002), despite secondary evidence that strongly suggests that asylum seekers and HCPs face multiple challenges, in both healthcare acquisition and provision respectively (Camilleri & Zammit, 2012; Forman; HUMA Network, 2011; IOM, 2013; Kopin & Integra Foundation, 2016; Luhman, Bouhenia & Giraux, 2007; Vjaters, 2014). Additionally, some of the literature provided in both chapter one and the present chapter, has shown how asylum seekers in Malta are generally surrounded by negative political and populist discourses (European Commission against Racism & Intolerance, 2007; Pisani, 2013; Falzon & Micallef, 2008; Frendo, 2006; OHCHR, 2015) and the potential impact that these discourses could have on health and healthcare have been highlighted through the findings of numerous studies presented above.

These observations, in addition to the discussion around the conceptualisations of race, ethnicity, culture and related concepts, have guided the choice of methodology and method used for this study. As a consequence of this, in addition to the utilisation of a postcolonial perspective as outlined in the following chapter, the discussion of the findings in Chapter 7 are presented through the seven dimensions of the candidacy framework as identified by Dixon-Woods et al (2006), which helps expose the influential elements that arise throughout the healthcare pathway. Furthermore, intersectionality theory, as discussed in Chapter 7, has additionally informed the analysis of the findings in recognition of the diverse experiences that arise out of varied multiple oppressions and in negation of the asylum seekers as a homogenous group.

The following chapter will provide a detailed description of the methodology and method utilised for this study.

Chapter 3: Methodology and Method

Introduction

Qualitative research is an umbrella term that encompasses a variety of methodologies with differing paradigm positions and perspectives that guide the research process (Lincoln, Lynham & Guba, 2011). The choice of paradigm is dependent on the researcher's worldview and the authenticity of a qualitative research study can only be established through a clear account of the methodology utilised and how this has influenced decisions throughout the research process; the researcher's positionality and role in the research; the research strategies and the analytic theory utilised (McGregor & Murnane, 2010). All of these will be presented in this chapter.

Methodology

Qualitative research seeks to provide an indepth understanding of a phenomenon within its specific context (Cresswell, 2007) and was therefore deemed to be an appropriate approach for this current study. The benefits of utilising naturalistic inquiry when conducting healthcare research have been highlighted by both Pope and Mays (1995) and Petty, Thompson and Stew (2012), who claimed that this method is especially useful when attempting to explore participants' realities of healthcare practice and provision as it helps throw some light on the complexities and variables that influence these healthcare encounters. It was deemed to be highly relevant in view of the increasing recognition of the impact that political, social and economic forces have on differential power and ultimately, on health outcomes and inequities (Commission on the Social Determinants of Health (CSDH), 2008; Kilbourne et al, 2006), which is of particular relevance in migrant health research (Malmusi et al, 2010). This, in addition to Davis, Nakayama and Martin's (2000) assertions that the quantitative assumptions of objectivity and homogeneity are not conducive to research related to ethnicity, has led to the decision of utilising a qualitative approach.

Ethnographic research involves the study of social groups and/or systems in their natural environment (Seale, 2004). Ethnography's capacity to elucidate both individual and collective experiences within a situational cultural context is an approach that is particularly suited to exploring issues related to culture (Cresswell, 1998) and to healthcare (Savage, 2006). Whilst ethnography aims to provide a cultural description of the society under study, critical ethnography goes further and through its acknowledgement of the power inequities at play, enables the researcher to expose previously unchallenged power structures and bring to light other alternatives to affect change (Thomas, 1993). Harrowing, Mill, Spiers, Kulig & Kipp (2010) discussed the appropriateness of utilising a critical ethnographic approach when researching health issues, claiming that "the use of a critical qualitative research method that emphasizes holistic human experience and its relationship to power and truth offers the opportunity to closely examine health challenges from the perspective of those who live with them daily" (p 241).

As described in the introductory chapter, from 2002 till 2014 Malta has experienced an upsurge of forced migration mainly from African countries, resulting in a negative political and media discourse that has contributed to a growing xenophobia (Jones, 2008) and discourses of an invasion on 'Us' by the 'Other' (Van Hooren, 2015). Furthermore, a populist exclusionary discourse and a lack of governmental commitment to integration has resulted in marginalisation and poverty for a substantial number of asylum seekers in Malta (Cardona, 2010). Healthcare professionals are acculturated within this very same society. This, in addition to Dorazio-Migliore et al's (2005) assertions of health care practice and processes being more about interactional contexts than cultural differences, warrants the utilisation of a research approach that guides one to examine clinical encounters through the interaction of oppressions within an historical and sociopolitical context and to present previously excluded knowledge from the voices of those who have been marginalized (Anderson, 2000). It is in view of this that critical ethnography, as described above, was chosen to inform the method of inquiry for the present study, which aimed to gain an insight into cross-cultural healthcare practices and provision through an exploration of clinical encounters.

Carspecken (1996) attested that the utilisation of a critical ethnographic approach results in research that has been influenced by the researchers' value orientations, as they attempt to uncover patterns of oppression and domination. It is therefore essential that the critical researcher becomes aware of personal perspectives and by providing an explicit description of these, illuminates how these subjectivities have influenced data collection and analysis (Rashid, Caine, Goetz, 2015). It is therefore pertinent to highlight that in line with the philosophical underpinnings of critical ethnography, I uphold a critical constructivist view of culture as dynamic and a belief that cultures are unequally positioned through power relations. My personal understandings of culture and other subjectivities pertinent to this study, as well as their potential impact on the interpretation and findings, are expanded upon and further discussed in an upcoming section entitled 'researcher positionality'.

Moreover, Madison (2012) claimed that the adoption of a critical ethnographic approach requires that details of the methodological processes utilised throughout the research study are presented. In view of this, an account of the methods employed in this study are provided in the upcoming method section. Prior to this, the following paragraphs specifically identify and locate the impact that critical ethnography has had on the various stages of the research design.

Critical ethnography aims to provide a holistic understanding of human experiences and this is enabled through the collection of a variety of data generation methods and sources (Carspecken, 1996). For this study, data were collated through participant observation, informal conversations, in-depth face-to-face interviews and field notes and were further informed by alternative sources including continuous self-reflection, multiple discussions with people working in the field and keeping updated with national and international developments in relation to forced migration and asylum seekers. This has resulted in the compilation of information from a diversity of perspectives and enabled a deeper understanding of the phenomenon under study.

As described above, critical ethnography is focused on power relations, with an aim to achieve emancipation (Gordon, Holland & Lahelma, 2001) and this focus has guided my

conduct during data collection, as well as other phases of the research process. Indeed, the methodological implications that this focus has had on corresponding issues such as reflexivity on power differentials and voice representation, are further discussed in the upcoming sections.

The utilisation of critical ethnography to guide the research design, necessitates the choice and application of a theoretical model that upholds a similar conceptual understanding of race, ethnicity and culture as dynamic and socially constructed (Mohammed, 2006). This and other tenets of postcolonial theory as outlined below, are complementary to critical ethnography and their combined application is highly conducive to exposing the impact that diverse postcolonial discourses have on social structures and the resultant inequities that arise out of this (Edward, 2013).

Postcolonial Theory

Postcolonial study is an umbrella term for a variety of discourses and approaches, predominantly connected to the work of Edward Said, Gayatri Spivak and Homi Bhaba (Quayson, 2000). Despite a diversity in its body of thought, the overriding focus is on the unmasking of western domination through an examination of the impact of past European colonialism and present day neo-colonialism on the cultures and societies of today (Ashcroft, Griffiths & Tiffin, 2007). One of the main tenets of postcolonialism is its critique of western epistemology as absolute truth and the cultural domination that results from this epistemological stance (Gandhi, 1998). In his groundbreaking book *Orientalism*, Said (2003), discussed the relationship between knowledge and power and showed how uncontested negative representations of Arabs served to provide moral justifications for imperialistic practices. Both Said (2003) and Spivak (1988) claimed that these representational discourses resulted in the creation of binary opposites and a European construction of the 'Other' as an inferior being. Drawing from Foucault, Spivak (1988) referred to the creation of the 'Other' and the absence of their contribution to knowledge, as 'epistemic violence' (p 24) and called for an honest and full representation of 'subjugated knowledge' (p 25) in all research endeavours. Representation, which is an 'understanding of how modes of representation work to create, maintain and to extend

hegemony' (Carter, 2004, p 826), is a key concept in postcolonial research and the utilisation of a postcolonial approach encourages an exploration of how both past and new forms of colonialism have resulted in master narratives being solely produced by the coloniser, to the detriment and subjugation of the colonised (Rutherford, 1990).

Whilst the benefits of globalisation are indisputable, there is evidence to show that it has also resulted in a rise in inequalities (Phillips, 2007) and 'new forms of colonialism' (Anderson, 2004, p242). Lynam (2005) discussed inequities directly related to health care provision and status and cited evidence that showed how these inequities are in fact the result of complex social conditions. Reimer-Kirkham & Anderson (2002) stressed the importance of the health care researcher focusing on the social dimensions of health and illness and Holmes (2012) asserted the necessity of consideration being given to the global context of migration and the impact of racial prejudice in social interactions. The validity of this is reinforced by the findings of a substantial number of studies, which strongly suggested that the quality of care provision to people from ethnic minorities is compromised by healthcare providers' feelings of uncertainty, incompetence and preconceived assumptions, with a subsequent lack of therapeutic engagement and marginalisation of the 'Other' (Browne, 2007; Browne and Fiske, 2001; Baker and Daigle, 2000; Burgess, van Ryn, Crowley-Matoka and Malat, 2006; Johnson et al, 2004; Kai, et al, 2007; Katz and Alegria, 2009; Pesut and Reimer-Kirkham, 2010). Browne (2007) claimed that these preconceived assumptions are a legacy of stereotypical images arising from a colonial past and its racialising discourse, strengthening Habib's (2008) call for the utilisation of cultural theories and models that look beyond a 'discourse of diversity' (p 187) and for the implementation of studies that would uncover the 'multiple jeopardies' that endanger migrants' health (Browne, 2007). The application of a postcolonial perspective to a critical ethnographic approach, would enable the researcher to effectively explore how historical forces have a continuing impact on health and healthcare provision, through a non-essentialist perspective (Mohammed, 2006). This is corroborated by Racine (2009), who affirmed the benefits of utilising a research method that is 'aimed at deconstructing the hegemonic discourses of racialization encountered at the individual, institutional and societal levels' (p 183) and through this, has the potential of transforming healthcare practices. The utilisation of a paradigm that places a focus on deconstructing

colonialisation is especially pertinent to a study carried out with asylum seekers in Malta, as during the period that the data collection for this study was carried out, the vast majority of these asylum seekers were African. These African countries and Malta share a long history of colonialisation.

After centuries of colonisation, Malta achieved independence in 1964, bringing 160 years of British rule to an end. Despite this change in governance, the Maltese authorities were reluctant to sever ties and the colonialised structural systems and discourses were retained (Frendo, 1988). Indeed, to this day, English is still one of Malta's two official languages. Because of Malta's small size and hence, limited lingual horizons, knowledge is imported from the West, with the resultant assimilation of a "colonial mentality" (Cutajar, 2008, p 35) and related racialising discourses. Racialisation pertains to categorising people according to race within a hierarchical structure that opens the way for racist practices and an understanding of this process requires an exploration of historical and political events (Miles, 1989 as cited in Bradby, 2003). Additionally, as discussed in Chapter 1, the continuous 'influx' of asylum seekers to Malta resulted in increasing sentiments of xenophobia and racism (Falzon & Micallef, 2008; Frendo, 2006), especially in relation to Africans (Amore, 2005).

As can be seen from the brief snapshot above, the postcolonial tenets of knowledge, history, identity and subjectivity, are all highly relevant to the local milieu and to a study that aimed to explore cross-cultural healthcare utilisation and provision through primary healthcare encounters. The use of these postcolonial tenets has helped guide me to unmask the multilayered currents of power, through a decolonisation of the research (Racine & Petrucka, 2009), relevant concepts were addressed throughout the research process when applicable, as outlined in the following sections.

Representation through a postcolonial lens which is loosely guided by critical ethnography, requires the researcher to be aware that power relations are not only influential in clinical encounters but also within the research relationship (Henry, 2007) and throughout the research process (Karnieli-Miller, Strier & Pessach, 2009). Lather discussed the importance of reciprocity in the researcher-researched relationship (as cited in Reimer-

Kirkham & Anderson, 2002), with reciprocity defined as an “optimal relationship with respondents based on dignity and respect” (Magolda, 2000, p 141) that can only be achieved if the researcher is aware of her own positionality in the research.

Researcher Positionality

The meanings that are ascribed to race, ethnicity and culture, influence all the stages of the research process. Conceptualisation of race, ethnicity and culture is marked by postcolonial theoretical perspectives that view race and ethnicity as social constructions, which vary depending on the historical context and the ways in which they are experienced (Dein, 2006). Culture is also seen to be fluid and flexible and highly complex, as it is shaped by “multiple contextual layers” (Racine, 2002, p 92) and as such, is continuously being defined and redefined (Rutherford, 1990). As evidenced in the previous chapter, the international literature suggests that a substantial number of healthcare professionals uphold an essentialist understanding of race, ethnicity and culture, which negatively impacts on their healthcare provision (Gates, 2009; Moscou, 2008). On initiation of this research study, I believed that this was also true of HCPs in Malta, making the adoption of a critical perspective crucial to this study. A critical approach has enabled me to look beyond race, ethnicity and culture as the sole and most relevant aspects of the participants’ identity (Mouzon, 2010) and in so doing, I have become aware of how these and other social determinants intersect to influence health and healthcare experiences (Guruge and Khanlou, 2004).

Identity and subjectivity are key concepts in postcolonial studies (Werbner, 2002), as is the ideology through which these are constructed and the power relations that these reproduce (Ashcroft et al, 2007). This requires the inclusion of the researcher as an ‘object of study’ (Chiseri-Strater, 1996, p119). This, in addition to critical ethnography’s focus on power relations, demands that the researcher carries out an honest and critical analysis of the above-mentioned concepts in relation to self and participant-researcher relations (Mohammed, 2006). I am Maltese, female, white, middleclass, a nurse educationalist and academic in the process of carrying out a doctoral study and irrespective of any good intentions for embarking on this research study, my positionality could impact negatively

on the desired outcomes (Spivak, 2010). Each of my identities have an impact on the participants' subjectivities of me, as well as my discursive practices that produces the 'reality' of the phenomenon under study (Foucault, 1980), with a potential to reinforce the power differentials that this research study aimed to deconstruct (Alcoff, 1991 – 1992). Indeed, one of the major criticisms of postcolonial research is that the privileged position which the researcher holds could result in "increasing or reinforcing the oppression of the group spoken for" (Alcoff, 1991 – 1992, p 7), a process that Mohanty (1984) has termed discursive colonialism. The negative implications of this process are especially salient in research relationships with vulnerable populations (Vanna, 2015) such as asylum seekers, whose vulnerability is greatly exacerbated through disempowering post-migration asylum and settlement policies and procedures (Morrice, 2011). This is corroborated by Berger (2015), who reported that individuals who have been placed in a position of vulnerability by inequitable social structures at the macro-level, will experience similar disempowerment on an interactive level.

Knowledge production and reproduction is another key concept in postcolonial research (Vanna, 2015) and in addition to the influence of the researcher's positionality on data collection during participant – researcher interactions as discussed above, the researcher's positionality further shapes the interpretation and presentation of the research findings (Berger, 2015). Utilising a critical ethnographic approach through a postcolonial lens, has guided me to closely consider my positionality in relation to representation and a major preoccupation throughout the research process was how, or even whether, I could represent the asylum seekers, in full cognisance of my privileged positions and the impact that these could have on the data. Moreover, how could I avoid essentialising the participants, which is a common outcome when representing the 'Other'? (Krumer-Nevo & Sidi, 2012).

The problematic issue of representing the 'Other' in research has been widely debated, especially in feminist literature, with opposing camps both providing convincing arguments of why researchers should, or should not attempt to speak for the 'Other' (Wilkinson & Kitzinger, 1996). Indeed, whilst Spivak (1988) affirmed that all research was mired in colonialist practices in terms of 'Othering' and also highlighted the researcher's potential role in harmful representations, she further critiqued the arguments that reject

representing the ‘Other’, with the claim that this action obscures the true power imbalances at play. In acknowledgement of the lack of viable alternatives, Alcoff (1991 – 1992) reported that in a variety of circumstances, speaking for ‘Others’ is the best option and further discussed how in these situations it is essential that researchers critically evaluate their influence on the data and the overall effect of the findings.

A number of strategies have been proposed to thwart ‘Othering’ from occurring, one of which involves providing the locational context of the participants, which has been termed “narrative” (Krumer-Nevo & Sidi, 2012, p 301). In an attempt to situate the participants of this study within their locational context, Chapter One provides an overview of the relevant migration history to Malta, including political and populist responses to this forced migration. Additionally, an overview of the healthcare setting, as well as pen portraits of the asylum seekers, are provided in the present chapter. To preserve anonymity in Malta’s small PHC sector, individual descriptions of the cultural mediators and healthcare professionals (HCPs) will not be provided. Reflexivity in terms of establishing one’s philosophical positions is another strategy that has been proposed (Krumer-Nevo & Sidi) and my world view has been discussed above.

Power imbalances and issues of representation have been a major concern throughout this research study. In addition to the strategies addressed above, this concern has led to a careful consideration of modes of recruitment, interactional processes and analytic forms that shape interpretation, all of which have presented their own challenges and have required particular responses, as will be discussed in the upcoming sections whenever relevant.

Method

Method refers to the specific strategies that are employed in a research study and this section describes these strategies in direct reference to the present study, which sought to gain an insight into crosscultural healthcare practices through an exploration of clinical encounters with asylum seekers in the PHC setting. Therefore, the following sections include a detailed account of the methods utilised for the present study and the rationale

underlying the choices taken, a discussion that addresses the ‘trustworthiness’ of the study and lastly, a section that discusses the theoretical and practical aspects of relevant ethical concerns. It will be pertinent to highlight that this process was not carried out in the linear fashion that the ensuing structural format suggests, but involved a dynamic movement back and forth across the stages.

Data Collection Methods

Data were collated through both observation that included informal conversations and in-depth interviews. This involved 130 hours of observation in two health centres and one non-governmental General Practitioner (GP) walk-in clinic that caters solely for asylum seekers. Additionally, in-depth interviews with 11 asylum seekers, two cultural mediators and seven healthcare professionals were carried out.

Data Collection: Participant Observation

Participant observation has been cited as a prime method of data collection when utilising an ethnographic approach to guide a research study (Hammersley & Atkinson, 2007). Over 50 years ago, Becker & Geer (1957) reported that participant observation is beneficial in situations where the participants might be reticent to disclose their reality of the situation under study, when the individuals in the group being studied are repeatedly stereotyped and when interviews are unlikely to reveal invisible social processes. There is evidence that shows how asylum seekers tend to minimise the problems that they encounter in their host country when asked (Goodman, Burke, Liebling & Zasada, 2014) and as illustrated in the literature review in the previous chapter, asylum seekers are regularly accorded stereotypical attributes (Fang et al, 2015). The literature review additionally demonstrated the complexity of PHC encounters between migrants and HCPs, with cross-cultural interactions and behaviours greatly influenced by national processes and institutional contexts, most of which are difficult to detect when analysing data derived from interviews. Indeed, to this day, participant observation is still cited as the foremost approach when one requires a holistic understanding of various experiences and their underlying social processes and as such, is considered to be optimal for “witnessing or

participating in phenomena of human interaction” (Mack, Woodsong, MacQueen, Guest & Namey, 2005, p14) within “situated occasions” (Thomas, 2014, p 61). Furthermore, participant observation helps develop the relevant content to be addressed in the ensuing interviews (Guest, Namey & Mitchell, 2012). It is in consideration of all of the above that participant observation in governmental Health Centres was chosen as the initial data collection method for the present study, with a target population that included asylum seekers above the age of 18 years, who attended the health centre for some form of medical services, as well as the attending healthcare professionals and cultural mediators.

Research Sites

In Malta, Health Centres are a focal point of the PHC services provided by the government. There are eight health centres spread around the Island, each of which, provide preventative, curative and supportive services within a specified catchment area. Health care practices and experiences are influenced by locational aspects. It is at these sites that hierarchies and relations of power are created and reproduced, often through a cascade effect of political ideology and policy on institutional systems, which subsequently shape the organisational culture and discourses (Poland, Lehoux, Holmes & Andrews, 2005). These latter authors defined place as “a set of ‘situated’ social dynamics” (p 172) and an ethnographic approach through a postcolonial perspective, requires that a full description of the setting is provided, based on an examination of the constructional elements that have given rise to the existent power structures and the impact of these on health care practice. The locational context is presented below, whilst the impact of political discourses on institutional policies and culture and ultimately healthcare encounters, is addressed in the discussion of the findings in chapter Seven.

The Physical Setting

Despite some differences in structure, the layouts of the Health Centres are relatively similar and to avoid accentuating any specific Health Centre, the physical settings described below are a general representation.

The Health Centres contain a minimum of one main area that provides the acute services and then other generally smaller spaces with clinics that provide specialist services, some of which are accessed through warren like corridors. Entry to the acute areas of the Health Centres lead to a reception area consisting of a waiting section with seating availability and with the receptionists' counters situated in dominating positions that are within earshot of some sections of these waiting areas. In some of the Health Centres, the receptionist counters are fitted with protective glass shields with speaker openings. These reception areas are equipped with television monitors attached at a raised level to one of the walls and these sets are generally tuned into one of the Maltese channels. The walls also contain religious icons relating to the Roman Catholic faith, as well as guide signs in English to direct patients to the clinics of the various services available. There are literature holders in the reception areas, with flyers and brochures pertaining to various health-related topics in the Maltese and/or English language. These acute reception areas all provide direct access to the General Practitioner (GP) clinics and the treatment room and commonly to other clinics, such as the wound clinic and the bleeding room. In the mornings the waiting rooms are inevitably crowded with queues of people waiting to speak to the receptionist, or sitting or standing around while waiting to access different services. All this activity tends to cause some confusion especially for newcomers, or those who have not as yet become accustomed to the system.

The GP rooms are generally small and contain a couch, a desk and a chair on either side of the desk, a sink and possibly a paper cabinet, and whilst the majority of the couches in these GP clinics have curtains that can be pulled around to enable patient privacy and dignity, there are a small number that do not. The treatment rooms are relatively spacious and have a number of cubicles with curtains, with each cubicle ordinarily containing a couch, a chair, oxygen cylinder and a trolley with commonly used medical equipment and healthcare products.

Apart from the acute areas described above, there are a substantial number of other rooms which are used for the specialist clinics and which have adjoining waiting areas that vary in dimension from sizeable spaces, to a few chairs placed along a corridor-shaped space. As mentioned above, some of these clinics are accessed through warren-like corridors with

multiple doors and despite the presence of guiding signs, a few of the clinics are not easy to locate. Indeed, when sitting near the receptionist desk during observation, I would often notice asylum seekers who had already been directed to the relevant clinic, returning to this waiting area to ask yet again where their clinic was located.

Entry to the Field

Initially I had planned to carry out observation in two Health Centres (A & B) and was granted signed permission to do so by the official in charge of data control in the Primary Health Care Department and the Nursing Officers of both Health Centre A & B. During the first period of my observational data collection, Health Centre B was under refurbishment and therefore, for this period data collection was carried out solely in the acute services in Health Centre A.

To avoid any possibility of coercion, contact with all potential participants was enacted through a third party. My entry to the field was greatly facilitated by a nurse and doctor working in management, whom I knew and who introduced me to the relevant HCPs and cultural mediators working in the acute services area at the Health Centre, further encouraging these HCPs to consent and participate in my research study. It was clear that my status as a nurse and therefore a member of one of the communities under study was pivotal to facilitating my access to the field. Following this introduction, I spent several days attending the Health Centre at 7.30am, which is generally a quiet time and this enabled me to further explain my study to the various HCPs employed at the Health Centre. Following a verbal explanation, I provided them with the relevant participant information sheet (PIS) (Appendix 1) and consent form (Appendix 2). This approach was used for the three periods that I re-entered the field, which enabled me to obtain informed consent from any new staff, including cultural mediators. furthermore, this strategy ensured that consent given in the past was still applicable, in acknowledgement of the importance of consent being an ongoing process (Sanjari, Bahramnezhad, Fomani, Shoghi & Cheraghi, 2014).

Out of all the HCPs, there were two doctors who preferred not to participate and during observation I ensured that no data was collected in relation to these two individuals. Once I had obtained written consent from the HCPs, I was ready to start and I timidly sat in the waiting area of the acute services. The plan was that once consent was obtained from the asylum seekers, I would accompany them on their visit to either the GP clinic, or other available services provided in the treatment room. Whilst written consent was obtained from all the individuals involved in the clinics that I observed, the waiting areas in Health Centres are categorised as quasi-public spaces and therefore individual consent was not required from the individuals who inhabited these spaces, especially once any interest on my part was collective, as opposed to individual (Tollefsen, 2008). Notwithstanding this and as described below, following an explanation of my study, the receptionists kindly accepted to be involved with the recruitment of the asylum seekers and were thus fully aware of my observational role.

Similar to the HCPs, contact with the prospective participant asylum seekers was enacted through a third party, once they registered with the receptionist of the Health Centre for the service that they required. Unless engaged elsewhere, I would be sitting in the waiting area and when the cultural mediator was available, he would ask the asylum seekers if I could approach them to explain my study and possibly obtain consent for their participation. If a cultural mediator was not available then the receptionist would ask for permission on registration. For those who accepted to be approached I explained the study to them after which, I provided them with the relevant PIS (Appendix 3) and consent forms (Appendix 2). For consent to be truly informed, participation should be voluntary and based on all relevant information pertaining to the study, which should both be provided to the potential participant and also fully understood by them (Gillam, 2013). Therefore, those asylum seekers who were unable to understand the details of the study and the implications of participation and could not provide their informed consent, were excluded from participating in this study. In situations where the cultural mediator was not available and the asylum seekers were not highly proficient in reading and writing English or Maltese, their understanding was ascertained in the presence of a witness, prior to consent being signed, or marked. Informed consent is highly complex and even more so in relation to studies involving asylum seekers and refugees, where research is often carried out within

challenging legal, political and socioeconomic contexts (Refugee Study Centre, 2010). A discussion of the complexities surrounding informed consent in relation to the present study is provided in the ethics section of this chapter.

Sites & Periods of Observation

Table 2 Research Sites and Periods of Observation

| | November 2012 – January 2013 | July – August 2013 | July 2014 | October – December 2014 |
|---|---|-------------------------------|------------------|--|
| Health Centre A | 50 hours | 40 hours | | 20 hours |
| Health Centre B | | | | 10 hours |
| Independent GP Clinic for Asylum Seekers | | | 10 hours | |

As illustrated in Table 2 above, the first observational period between November 2012 and January 2013 was carried out solely in Health Centre A, as was the next observational period in July and August 2013. During this second period, in addition to the acute services, I also spent 20 hours observing two specialist clinics. My third and last phase of observational data collection was carried out between October and December 2014 and whilst I did spend some hours at Health Centre B, most of these hours were spent in the waiting area as a result of the lack of asylum seekers attending this clinic. This, in addition to the relevancy of the rich data that I was gathering from Health Centre A in direct relation to my research question, guided my decision to carry out the rest of that observational period in Health Centre A, totalling up to 120 observational hours. Whilst an ethnographic approach encourages multi-sited research, this does not refer only to different geographic locations but that the sites themselves are spatially different, creating

knowledge originating from newly forged connections between a variety of structures and discourses (Marcus, as cited in Gunaratnam, 2003).

In July 2014 I was afforded the opportunity to spend 10 hours observing a walk-in General Practitioner (GP) clinic that is non-governmental and run on a voluntary basis and which was set up to serve asylum seekers specifically. This opportunity was fortuitous, as it gave me the possibility of observing a diverse setting and situation where in most of the instances, healthcare interactions occurred within a previously formed trusting relationship between the asylum seeker and the doctor.

Additionally, throughout this study, I have had plenty of informal conversations with professionals and other individuals working in governmental and nongovernmental organisations (NGOs) that provide support to asylum seekers in a variety of areas including those related to asylum status, physical and psychological health and diverse social matters. Not only did these professionals generously share their many experiences with me but I was also invited to participate in a number of different activities and projects involving asylum seekers, healthcare professionals and professionals from other disciplines. Lastly, throughout the course of the present study, I kept track of both the national and international situation in relation to forced migration and discourses around asylum seekers that also included the constant perusal of comments posted on Maltese newspapers in response to relevant articles. Tracing asylum seekers' and healthcare professionals' experiences across these diverse spaces, has enabled me to adopt a multi-sited imaginary as discussed by Gunaratnam (2003), which has involved a continuous methodological consideration of my own positionality in relation to these various discourses and structures as they emerged.

Observing Encounters

The majority of encounters that I observed were those between asylum seekers and HCPs, namely doctors and nurses, either when the asylum seekers attended the walk-in GP clinic, or when they were being attended to in the treatment room, or in the two specialised clinics, one of which, is nurse led. My observations of the clinical encounters mainly

focused on the interactive communication processes and behaviours, relationship building, decision-making strategies and information exchange, with a consideration of the contextual elements within which these clinical encounters occurred.

Fieldnotes are a major feature of observational data collection in critical ethnography and despite a variety of approaches, the practice generally involves recording descriptions of places and events and the researcher's reflections on these events (Murphy & Dingwall, 2001). Despite the benefits of using audio recordings for accuracy of recall (Perakyla, 2004), I felt that the potential discomfort which could arise from this added intrusion on the participants' privacy outweighed any benefits and therefore the observational sessions were not audio recorded. As my written fieldnotes were the only tangible evidence of my observations, I was initially busy writing down detailed descriptions as they occurred. I soon realised that this practice interfered with my ability to register other important observational cues and I started writing briefer notes which I then expanded upon straight after the encounters. Nevertheless, I would still attempt to write verbatim certain experiences that participants described and other comments passed during informal conversations. My notes were divided into three sections, namely: the descriptions of the actual events and direct citations; my observations and reflections on the potential meanings of these and related events; and reflections on my personal responses to these. In this way, the various components of the fieldnotes were gathered in one logbook which was found to be especially useful when reflexivity was required to address the diverse technical, ethical and methodological issues that arose throughout the research process.

One of the disadvantages of observational research is the effect that the researcher's presence has on participant behavioural modification and furthermore, the difficulty of ascertaining the extent of this (Browne, 2007). In this study, the possibility of this occurrence amongst the HCP participants was amplified by my role as a nurse educationalist and this could have resulted in a number of healthcare professionals, especially nurses, perceiving me as an authoritative figure and modifying their behaviour. I attempted to minimize this limitation through the development of egalitarian relationships and a meticulous compilation of field notes, accompanied by constant reflexive analysis. The development of egalitarian relationships with asylum seekers was virtually impossible,

in view of the nature of our encounters and factors such as meeting them only once, limited time and the imposition of certain conditions by the ethics review boards, all of which further reinforced asymmetrical power relationships. This was even more of an issue in the absence of a cultural mediator whose presence would, to a certain extent, help counteract these power imbalances. Again, extensive field notes, reflexive analysis, and a postcolonial lens, were the strategies that I utilised in an attempt to check these limitations.

Whilst the main focus of my participant observation was on the diverse characteristics that typify clinical encounters, it also included observation of relevant aspects of the setting and a substantial amount of informal conversations with asylum seekers, cultural mediators and HCPs, as evidenced in the findings chapters. Conversations with the asylum seekers would take place in the waiting area prior to their medical visit and these would generally consist of a question and answer format, whilst conversations with the cultural mediators were far more balanced, with an equally shared conversation pattern. Informal conversations often took the form of a discussion between various healthcare professionals and myself in the treatment room during quiet periods, which would invariably start with one of the HCP's saying "Oh yes, you're the one looking at illegal migrants ..." and this would lead to a long discussion that not only addressed HCPs' views with regard to providing healthcare to this cohort of patients but also, on their personal attitudes to forced migration and related issues. Other discussions exposed attitudes that clearly demonstrated how asylum seekers are constructed depending on relational contexts and furthermore, are placed on a hierarchical scale according to their categories of difference. This data was highly valuable for both the provision of a holistic overview of the phenomenon under study, as well as for the formulation of an interview framework that would address the salient issues in the ensuing in-depth interviews.

Data Collection: Semi-structured In-depth Interviews

Interviews are another common form of data collection in ethnographic research (Madden, 2010), as they generally allow for an insider perspective and a deeper understanding of the participants' experiences of cross-cultural healthcare (Birks, Chapman & Francis, 2007). Additionally, when combined with participant observation,

the knowledge that is generated from interviews further explains observed activities and interactions (Hammersley & Atkinson, 2007). In this study, in-depth interviews were carried out with eleven asylum seekers (Table 3), two cultural mediators (Table 4) and seven HCPs (Table 5). Three different interview guides were developed and used for the indepth interviews with asylum seekers (Appendix 4), HCPs (Appendix 5) and cultural mediators (Appendix 6) respectively. The questions in these guides originated mainly from the key issues that emerged following an initial analysis of the observational data, which is a strategy that negates the researcher as the main originator of knowledge and is therefore beneficial in research that aims to provide an honest representation of subjugated knowledge. Moreover, I discussed the content of these guides with my academic supervisors and with experts in the field. Lastly, the questions on these interview guides were not asked in the manner, or order that they appear, as this formal and rigid approach would have reinforced the asymmetrical power relations that I aimed to minimise.

Recruiting Asylum Seekers

Hammersley & Atkinson (2007) reported how the selection of interviewees in ethnography is occasionally determined by factors such as difficulty of access, with migrants commonly cited as one of the hard-to-reach categories (O'Reilly-de Brun et al, 2016; Shaghaghi, Bhopal & Sheikh, 2011) and with asylum seekers often referred to specifically (Flanagan & Hancock, 2010; Wahoush, 2009). For the interviews with asylum seekers I had originally planned that following the observational period, I would purposively recruit a small number of the asylum seekers that I had observed and whom I believed could provide further valuable information. Indeed, the PIS (Appendix 3) clearly states that I might contact the participants for an interview at a later date and the consent form (Appendix 2) includes a statement that confirms the participants' agreement to this. Notwithstanding this and irrespective of them signing the confirmation, I felt that the few asylum seekers whom I did ask were very uncomfortable with providing me with their contact mobile number. On reflection, this request could have further negated assurances of anonymity as discussed above, or possibly compromised their sense of security.

Therefore, after the first day, I refrained from asking any of the asylum seekers for a contact number and abandoned my original recruitment plan.

The term hard-to-reach has been critiqued for its lack of a well-delineated and standardised definition (Flanagan & Hancock; Sydor, 2013) but despite this, it is generally understood to refer to a heterogeneous group of people who for a number of diverse underlying reasons, are “generally floating populations and socially invisible” and therefore are difficult to access for either research, or service provision purposes (Shagaghi et al, 2011, p 87). NGOs have been cited as ideally placed to access the hard-to-reach populations (Flanagan & Hancock) and the professionals working within the NGO that I approached generously accepted to select and recruit participants for the interviews. The inclusion criteria required that participants were asylum seekers, above 18 years of age and were purposively recruited because of having experienced a variety of PHC services in Malta. Five participants were recruited and these interviews were held in February 2014 at the NGO premises. Following this, I approached the managers of the Open Centres and one of these managers accepted my request and introduced me to the professional staff, who kindly selected and recruited a further five participants, whom I interviewed in July 2014 at the Open Centre. Lastly, I had the opportunity to carry out an interview with another asylum seeker, who was selected and recruited by a cultural mediator that I had met during an activity organised by the Migrant Health Unit. This last interview was held in December 2014 at a community centre. Out of these 11 participants, four were female and seven were male and four (two females and two males) of the interviews were carried out with interpreters.

Table 3 Asylum Seekers Participating in the Interviews

| Name & Age | Country of Origin | Immigration Status | Arrival in Malta | Interpreted Interviews |
|-----------------------|--------------------------|--|-------------------------|-------------------------------|
| Simret; 54yrs | Eritrea | Subsidiary Protection | 2011 | |
| Amiir; 33yrs | Somalia | Subsidiary Protection | 2012 | Interpreted Interview |
| Ndidi; 34yrs | Nigeria | Subsidiary Protection | 2011 | |
| Nkem; 33yrs | Nigeria | Subsidiary Protection | 2011 | |
| Baba; 27yrs | Mali | Rejected following appeal | 2012 | |
| Caadil; 53yrs | Somalia | Subsidiary Protection (to be resettled in USA) | 2009 | Interpreted interview |
| Sabo; 28yrs | Somalia | Subsidiary Protection (to be resettled in USA) | 2011 | Interpreted interview |
| Maryan; 25yrs | Somalia | Appealing rejected status | 2013 | Interpreted interview |
| Patrick; 41yrs | Sierra Leone | Humanitarian Protection | 2002 | |
| Akram; 28yrs | Iraq | Rejected following appeal | 2010 | |
| Daleel; 38yrs | Somalia | Humanitarian Protection | 2013 | |

Short portraits of these participants are given here to contextualise the interview findings as advocated when utilising a critical ethnographic approach (Edward, 2013). Each participant has been given a pseudonym.

Simret is a 54-year-old Eritrean man, who has been in Malta since 2011 and is on subsidiary protection. Simret lives in the community and at the time of the interview in 2014, his wife was pregnant with their seventh child. Since his arrival, Simret escaped to Norway with his family but was caught and sent back to Malta. He also applied for

resettlement to the USA and both him and his family were bitterly disappointed when they were refused. Simret is presently unable to work because of a physical ailment for which he is eagerly awaiting an operation but has not as yet been given a date for this. Simret is proficient in the English language and his children can speak and understand Maltese. Simret and his family are Muslims.

Amiir is a 33-year-old Somali man, who has been in Malta since 2012 and is on subsidiary protection. He lives in the community with a group of other Somalis, whom he met in an Open Centre. His wife, three children and his parents are in Iran and he is in frequent contact with them, as well as with other relatives in Somalia. He is presently recovering from tuberculosis and is unable to work. Amiir does not understand, or speak English and the interview was carried out with an interpreter. Amiir is a Muslim.

Ndidi is a 34-year-old Nigerian woman and has been in Malta since May 2011 and is on subsidiary protection. At the time of the interview in 2014, Ndidi was pregnant. She has a Nigerian partner and lives in the community. She ran away from Nigeria because she was forcibly married to a much older man and was being abused by this man's son from a previous marriage. Once Ndidi got to Libya, she was forced into prostitution but managed to run away to Malta during the Arab Spring uprising. On arrival in Malta, she was locked in detention, where she suffered mental health problems and was admitted to the psychiatric hospital for treatment. During her time in detention, Ndidi met Nkem (presented below) and they are now close friends. Ndidi is presently unemployed but is not presently looking for a job because of her pregnant status. Ndidi is very proficient in the English language and is Christian.

Nkem is a 33-year-old Nigerian woman and has been in Malta since December 2011 and is on subsidiary protection. A female friend who told her that she could lead a much better life in Libya, lured her away from Nigeria. Once in Libya, this friend forced her into prostitution and similar to Nkem, Ndidi ran away during the Arab Spring uprising. She spent one year and one month in detention and during that time was admitted to the psychiatric hospital because she was "*thinking too much*". At the time of the interview, Nkem was pregnant and lived in the community with her Nigerian partner. Nkem is

presently unemployed but is not looking for a job because of her pregnant status. Nkem is proficient in the English language and is Christian.

Baba is a 27-year-old male from Mali, who has been in Malta since 2012 and is on a rejected status following appeal. Baba ran away from Mali because he feared for his life and cannot understand why the Maltese authorities do not believe his need for asylum. He appears to be very bitter and angry because of this rejection. He has no family here in Malta and says that he is not in contact with his family abroad. Whilst in Malta, he has been admitted to the psychiatric hospital with mental health problems and is presently living in one of the Open Centres. He speaks English proficiently and is Christian.

Caadil is a 53-year-old male from Somalia, who has been in Malta since 2009 and is on subsidiary protection. He has a full time job and lives in the community. At the time of the interview, he was waiting to be resettled to the USA following his successful application. Despite Caadil speaking and understanding a little bit of Maltese, the interview was carried out through an interpreter. Caadil is a Muslim.

Sabo is a 28-year-old Somali woman, who has been in Malta since December 2011 and is on subsidiary protection. She and her husband left Somalia because of the war, leaving a son behind who lives with her family. Sabo lives in the community with her husband who is unemployed and another son, who is one year two months old. At the time of the interview, she and her family were waiting to be resettled to the USA following their successful application. Sabo could not understand or speak English and the interview was carried out through an interpreter. Sabo is a Muslim.

Maryan is a 25-year-old Somali woman and who has been in Malta since 2013 and who, at the time of the interview, was appealing a rejected status. Maryan left Somalia because of the war and came to Malta to be united with her sister Sabo, who is described above. Maryan was raped whilst in Libya, as a consequence of which, she now has a 6-week old baby. She lives in one of the Open Centres. Maryan cannot understand or speak English and the interview was carried out through an interpreter. Maryan is a Muslim.

Patrick is a 41-year-old man from Sierra Leone and arrived in Malta for the first time in 2002 and is on humanitarian protection. Since 2002 he has been to Denmark twice and has been sent back to Malta both times. Patrick's parents live in Sierra Leone and he is in frequent contact with them. He has been admitted to the psychiatric hospital for a mental health problem. Patrick has a fulltime job and lives in the Open Centre. Patrick is proficient in English and is a Christian.

Akram is a 28-year-old man who is from Iraq and arrived in Malta in 2010, after having travelled through Egypt and Libya for approximately 6 years. Akram is on a rejected status following appeal, although he reported that there did not seem to be any immediate plans for him to be sent back to Iraq. Akram is unemployed, although he said that he occasionally has temporary painting jobs. Akram is being treated for a mental health problem but has never been admitted for inpatient psychiatric care. Akram lives in an Open Centre and speaks and understands both English and Maltese. Akram is a Muslim.

Daleel is a 38-year-old man from Somalia who has been in Malta since 2013 and who is under humanitarian protection. Daleel suffers from a chronic psychiatric problem for which he has been in and out of the psychiatric hospital and which he reported was the result of a car accident, *"my mind broke with the stones"*, that occurred when he was escaping Somalia. Daleel appears to be well educated and had a successful business in Somalia, following his obtaining a diploma in business administration. At the time of the interview, Daleel was unemployed and lived in an Open Centre. Daleel is proficient in the English language and is a Muslim.

Recruiting Cultural Mediators

A person who has direct contact with the cultural mediators discussed my study with five of them and as they agreed to participate in the interviews, she obtained their permission to send me their contact details. When I contacted them myself a week later, only two consented to an interview and these interviews were held in June 2015 at their choice of location. Nevertheless, I had various opportunities to meet and have long informal conversations with two other cultural mediators who I had the good fortune to encounter

on a variety of occasions. Pseudonyms have been provided when referring to these in the findings namely Jamaal, Iman, Meraf and Ouma. The four cultural mediators were under 35 years of age and as can be seen from Table 4, minimal personal information has been provided to preserve their anonymity in Malta's small PHC sector.

Table 4 Cultural Mediators Participating in Interviews & Informal Conversations

| Name | Country of Origin | Data Collection Method |
|-------------|--------------------------|-------------------------------|
| Ouma | Senegal | Indepth Interview |
| Iman | Somalia | Indepth Interview |
| Meraf | Eritrea | Informal Conversation |
| Jamaal | Somalia | Informal Conversation |

Recruiting Healthcare Professionals

Seven HCPs were recruited from both Health Centre A (n 5) & B (n 2) and the sample consisted of five nurses (3 females and 2 males) and two doctors (1 male and 1 female). I approached and invited the HCPs in Health Centre A to participate in the interviews directly, as they had granted permission for me to do so in the consent form they had previously signed. These five HCPs were specifically chosen because they represented a wide array of years of experience and assumed different roles. The two HCPs (1 female and 1 male) from Health Centre B, were selected and recruited by the management, who then provided me with their contact details. The seven interviews were held in April and May 2015 at the participants' preferred locations. Pseudonyms have been provided for the HCPs who were interviewed and for reasons of anonymity as described in the above section, individual descriptions are minimal. At the time of the interviews, these HCPs had

a varied work experience ranging from a few years to over fifteen years since having qualified.

Table 5 Healthcare Professionals Participating in the Interviews

| Name | Profession |
|-------------|-------------------|
| Anna | Doctor |
| Carmen | Nurse |
| Joseph | Nurse |
| Maria | Nurse |
| Mark | Nurse |
| Miriam | Nurse |
| Tony | Doctor |

The Interviews

Reflecting on one's positionality is essential throughout the research process and this is especially crucial when embarking on each new phase of this process (Sanchez – Ayala, 2012). My positionality within this research and in relation to the participants, especially the asylum seekers, has been discussed in detail above and is further referred to when deemed relevant below.

Prior to the interviews I explained my study, provided the participants with the relevant PIS and answered any questions they had, following which I asked them to sign the corresponding informed consent (Appendix 7). A practice, which despite being ethically suspect when carried out with culturally-diverse participants, is still generally required by ethic review boards (Birman, 2006; Ellis et al, 2007), as evidenced by the related discussion in the upcoming ethics section. The interviews lasted between 45 minutes to 90 minutes and were audio taped, except for two interviews with asylum seekers and two with the cultural mediators, who asked for their interviews not to be recorded. In these instances, during the interviews I wrote down the main points that these participants raised

and once the interview was over, I immediately expanded on these points to ensure that I did not exclude the finer detail of the generated data.

Interviewing: Insider/Outsider Positions

Insider/Outsider status is one of ethnography's main categorisations of the researcher's position in relation to the participants, with advantages and disadvantages equally allocated to both positions (Carling, Erdal & Ezzati, 2014). These positions refer to whether the researcher is a member of the group under study and is a categorisation that has been criticised for being essentialist, as it fails to acknowledge a variety of other equally important identifiers (Dwyer & Buckle, 2009).

In migration research, insider status refers to the researcher having the same ethno-national origin as the participants, whilst outsider status refers to the researcher having the same ethno-national origin as the host population (Carling et al, 2014). This categorisation means that for my interviews with the asylum seekers and cultural mediators, I was in an outsider position because of a diverse ethno-national origin, which as can be seen from the above descriptions, the participants themselves did not share with one another. As mentioned above, this simplified perspective of researcher position has been challenged, not least by the concept of super-diversity that acknowledges the presence of, and interplay amongst, multiple variables within one individual and their contextual impact on that individual's positionality (Vertovec, 2007). Indeed, the extent of participant contributions to knowledge could be influenced by identifiers of difference between them and the researcher and this could have an impact on the data generated (Rubin & Rubin, 2012). This once again highlights the importance of the researcher undertaking a reflexive approach throughout the research process and in this specific instance, with a focus on the impact of similarities and dissimilarities on the interview process (Bryne, 2004).

In relation to the participant asylum seekers' and cultural mediators' positionalities, my own positionality, as outlined above, was marked by varying multiple differences. I was faced with a challenging situation in view of Bott's (2010) assertions that this could lead to 'Othering' practices by both parties. To counteract the negative impact of these multiple

differences, I implemented two strategies that the ethnographic literature proposed as effective plans of action (Hammersley & Atkinson, 2007; Bott). The first involved acknowledging the participant as the expert and encouraging him/her to assume this role (Hammersley & Atkinson) and the second, was recognising and empathising with their testimonies of hardship and injustice (Bott). Despite my showing empathy, I was and still am, fully aware of my inability to truly understand the totality of their experiences, both past and present and this awareness has motivated me to fully examine relevant contextual influences, which could help achieve honest representation.

Irrespective of having a similar nationality and being a member of one of the caring professions, there were also a variety of dissimilarities between the HCPs and myself and as opposed to neatly fitting into one position or another, I would often find myself alternating between insider and outsider positions. I knew the vast majority of the HCPs whom I interviewed, a circumstance which is practically inevitable in Malta, especially when one considers that I have been involved in HCP education since 1988. As mentioned above, my position as a nurse educator greatly facilitated access and I faced no problems in recruiting the seven HCPs for the interviews, whose work experience ranged from five years to 35 years. The interviews were generally conversational in style and whilst there were two participants who initially appeared to be holding back information, they became much more expressive as the interview progressed. Incidentally, this initial unwillingness to provide detailed information was evident in five of the asylum seeker interviews but apart from one who found an excuse to end the interview after 45 minutes, the remaining four provided increasing information as the time went by. This is similar to results from a study that examined three cross-cultural interviews and found that in the primary interviews the participants were also initially unwilling to provide information and one of the reasons that they gave for this was a fear of being misrepresented (Roer-Strier & Sands, 2015).

Interviewing: Power and Power Relationships

There is a general notion that it is the researcher who holds the exclusive power in research interviews but this is only partly correct, because despite the researcher being in control of

the structure that will shape the interview, the participant has the power to withhold the required information (Karnieli- Miller et al, 2009). Indeed, semi-structured interviews pose an ethical dilemma for the researcher who adopts a critical stance that aims to challenge power imbalances and oppressive practices (Karnieli-Miller et al). The dilemma arises out of the researcher's struggle to elicit as much meaningful information as possible, whilst simultaneously showing due respect to the participant by refraining from intrusive and manipulative practices (Brinkman & Kvale, 2005).

The researcher's ability to create a safe environment for the participant and utilise rapport-building strategies to help develop a balanced and mutually trusting relationship with the participant, has been cited as key to data generation (Karnieli-Miller et al, 2009).

Notwithstanding this, Dickson-Swift, James, Kippen & Liamputtong (2006) attested that some behaviours associated with rapport-building, such as the researcher disclosing personal information, is a form of control, since it has the purpose of eliciting data that the participant is unwilling to provide. Indeed, the dialogue that engenders an empowering and sympathetic environment, can within itself, simultaneously hide and reproduce power differentials (Kvale, 1996). Cognition of this, as well as the utilisation of a critical ethnographic and postcolonial approach to guide my study, demanded that attention be given to the development of egalitarian relationships and the facilitation of dialogical exchanges, through which, the participants' voices could emerge (Browne, Smye and Varcoe, 2005).

I found this especially challenging in the interviews with the asylum seekers who, with the exception of the cultural mediators, I only had the opportunity to meet on the one occasion. Power structures can be reinforced throughout the research process, including the compilation of interview guides (Vandenberg & Hall, 2011) and in view of this, I discussed the asylum seeker interview guide with a cultural mediator, to ensure relevance and appropriateness and possibly increase "participant power" (p 28). Furthermore, these guides were adapted as deemed necessary throughout the interview process, based on a continuous critical review of the interviews that had already taken place. As mentioned above, during the interviews with all of the participants I persistently encouraged them to take the expert role, by repeatedly reminding them that the information I sought was an

account of their unique experiences of healthcare utilisation, or provision, which only they could provide. This was more difficult to achieve with the HCPs, who were all aware of my educationalist role and who needed added constant assurances that there were no right, or wrong answers. Finally, as I was fully aware of the risk of utilising manipulative strategies to ingratiate myself with the participants and obtain the information I required, I was continuously on my guard to avoid this behaviour.

Power and power relations are inconspicuously imbued throughout the research process (Brinkman & Kvale, 2005) and are continuously being negotiated and renegotiated within all research relationships (Wong & Poon, 2010). This necessitates an honest and reflexive approach of the impact that various positionalities have on the power structures and the strategies that would encourage the formation of egalitarian relationships, which in turn would enable representation of subjugated voices.

Interviewing: The Interpreted Interviews

With the aim of representing subjugated voices, the inclusion of non-English speaking asylum seekers in the interviews was deemed to be inevitable. This entailed the use of interpreters, which has been found to greatly influence the interview process (Suurmond, Woudstra & Essink – Bot, 2016) and the nature of the knowledge generated (Wong & Poon, 2010).

Out of the 11 participants in this study, two Somali women and two Somali men required an interpreter. For two of the interviews I was assisted by a Somali male interpreter, who had been trained specifically to work in interpretation with the NGO who facilitated my first group of interviews and with whom he was employed on a part-time basis. Another of the interpreted interviews was carried out by a Somali male, who had trained as a cultural mediator aiming to work in healthcare but was, at the time of the interview, working temporarily as an interpreter with a community organisation. The fourth interpreted interview was facilitated by a Somali male, who had no previous training in interpretation and whilst he appeared to have a good understanding of the English language, his strong accent made it sometimes difficult for him to be understood. This resulted in my main

focus being placed on trying to understand what was being said, with minimal attention paid to other important cues, which had the potential to limit my comprehension of the situation in its totality. However, I did manage to understand all the dialogue once I heard the recorded tapes following the interview.

The literature on interpreted research interviews refers to technical/procedural (Plumridge et al, 2012) and epistemological challenges (Fersch, 2013; Ingvarsdotter, Johnsdotter & Ostman, 2010; Temple & Young, 2004), with an emphasis placed on the influence that interpreters have on the final outcome (Suurmond et al, 2016; Wong and Poon, 2010). The recommendations related to the technical and procedural challenges are conflicting and include the choice of interpreter, with arguments both for and against the use of an interpreter who is known and respected by the participants (Ingvarsdotter et al), as well as researcher choice in terms of the interpreters' certified qualifications and linguistic skills (Squires, 2008). Choice of interpreter was not an option in my study, as the first NGO who facilitated participant recruitment insisted on providing their own interpreter for the two interpreted interviews. Whilst there is literature that reports how the use of an interpreter who is familiar to the interviewees has the potential to hinder the participants from divulging personal and sensitive information (Sanchez – Ayala, 2012), this definitely was not the case with at least one of the two participants, who brought up a personal issue that she had only disclosed to a very select few. I also did not have a choice in the selection of the other two interpreters, one of who was provided by the second organisation and the third, who as described above, recruited the participant himself. These two interpreters assumed a passive style, which raises the probability of true voice representation but is unfavourable in that it fails to situate voice within the relevant cultural context (Ingvarsdotter et al). I felt that this drawback was overcome in the interview facilitated by the qualified cultural mediator, who provided cultural contexts to what was being said once the interview was over. Moreover, I found that this method was beneficial in the way that it helped me to distinguish between the participant's and interpreter's voices.

Other common technical/procedural recommendations that address the challenges include: matching characteristics such as age, gender, ethnicity between the participant and the interpreter; diverse recommendations on the best mode of interpretation; and seating

arrangements (Plumridge et al, 2012; Squires, 2008; Suurmond et al, 2016; Wallin & Ahlstrom, 2006). The majority of these guidelines highlight the importance of meeting the interpreter to discuss these issues prior to the interview (Wallin & Ahlstrom) and in the present study, this was carried out with two of the interpreters in three of the four interviews. During these meetings, I explained the nature and purpose of my study, the information that I required, showed them the interview guide and we discussed my expectations and their interpreter modes. Notwithstanding these discussions, I had some doubt as to the precision of interpretation in two of the interviews, as the interpreter would have long, animated conversations with the participants and then turn to me and utter one word, with no explanation of what had just transpired. Results from a study that analysed interpreted research interviews showed that all interpreters edited the information provided by the interviewee (Suurmond et al) and I tried to overcome this obstacle by repetitive and constant probing, especially when I sensed that this had occurred.

Ingvarsdotter et al (2010) highlighted how recommendations such as those discussed above, are generally based on conflicting evidence and further attested that whilst guidelines that address interpreted research interviews are beneficial, it is the individual context that should ultimately guide specific practices. These authors additionally cautioned against the unquestioned use of technical procedures in the false conviction that trustworthiness would be ensured, whilst simultaneously ignoring the broader methodological issues. The importance of addressing epistemological issues in interpreted encounters is also referred to by other authors, who highlighted the impact that an interpreter could have on the interview process and the generation of data (Hennink, 2008; Larkin, de Casterle & Schotsmans, 2007; Temple & Edwards, 2002). The term “triple subjectivity” was coined by Temple and Edwards (p 6) and it provides a true representation of the influential processes within the triadic research interview and in so doing, negates a concept of the interpreter as a neutral channel of information.

An acknowledgement of the interpreter’s influence demands that reflexivity in terms of the interpreter’s positionality should be actuated and this would include learning about the interpreters’ background, their personal philosophy, their views on and experiences of the topic under study and if they have any personal agenda (Temple & Edwards; Hennink). As

mentioned above, in my study pre-interview meetings were carried out with two of the interpreters and post-interview meetings with all three of them and the gathered information was referred to and reflected upon, throughout the processing of the data.

Processing the Data

Transcription

Transcribing is not merely a technical skill but involves decisions in relation to the amount and nature of detail recorded and furthermore, is subject to methodological interpretation (Bailey, 2008). As a result of this, transcription encompasses diverse approaches and the choice of approach is the first step of this phase (Oliver, Serovich & Mason, 2005). In view of transcription being an interpretative process and because I was cognisant of the context within which data collection occurred, I chose to carry out the transcription myself. Additionally, transcribing helped me to become conversant with the data, as required by the thematic analysis approach that I utilised (Braun & Clarke, 2006).

The writing up of my 130 hours of observational fieldnotes was carried out on a regular basis at the end of each observation session. Madden (2010) referred to these as “consolidated notes” (p 124) and further asserted that they were essential to ensure the collection of rich field notes. My “consolidated notes” were divided into descriptive and reflective sections and were revisited at the end of each of the three periods of data collection and again reviewed, prior to returning to the field. This strategy enabled me to seek a clarification and/or deeper examination of potentially relevant ideas that arose in each of these stages (Rapley, 2011).

Transcription of the audio reported interviews were carried out at the end of each batch of interview periods and were carried out verbatim. Written notes were taken for the other four interviews that were not recorded and these four were then expanded upon and written up after each respective interview. Attention was placed on ensuring that the punctuation used throughout the transcriptions provided an honest portrayal of the participants’

intended meaning and additionally included information with regard to pauses and other meaningful nonverbal cues (Braun & Clarke, 2006).

Data analysis

Data were analysed inductively using thematic analysis as developed by Braun & Clarke (2006), which enabled a systematic approach to my analysis of the data (Howitt & Cramer, 2008). Whilst it has occasionally been cited as exclusive to phenomenological research (Guest, MacQueen & Namey, 2012), thematic analysis is generally viewed to be simply a method as opposed to a methodology and is therefore compatible with research that utilises a variety of theoretical approaches, including those that employ a critical framework (Braun & Clarke). One of the main criticisms of thematic analysis is that it does not enable an in-depth interpretation of the data, although Braun & Clarke (2014) argued that this issue is related to, and dependent on, the researcher's ability and not the method. This corroborates Liamputtong's (2009) assertions that data analysis is an endeavour that requires specific skills to achieve a satisfactory level of proficiency.

Thematic analysis is used when the researcher aims to "identify, report and analyze data for the meanings produced in and by people, situations and events" and has been employed across a range of disciplines and topics (Floersh, Longhofer, Kranke & Townsend, 2010, p 2). Whilst this method advocates a search for patterns across the data, frequency does not automatically mean that a topic is of "substantive significance" (Patton, 2002, p467). Additionally, analytic frameworks which are of great help to systematically guide researcher engagement with the data, do not alone guarantee the emergence of substantively significant themes (Hammersley & Atkinson, 2007). Throughout the process, I constantly reviewed and questioned the coherence, consistency and potential purpose of emerging ideas (Patton).

Braun & Clarke (2006) identified six non-linear phases associated with thematic data analysis and the first five have guided the analytic process of this study, namely: familiarisation with data; generating initial codes; searching for themes; reviewing potential themes; and defining and naming themes.

Phase 1: Familiarisation

This refers to a comprehensive familiarisation of the data prior to formal coding and in my study this accumulative process started during data collection, on to transcription and lastly, through active reading and rereading of the transcribed data (Braun & Clarke, 2006). Notes in relation to my initial thoughts and ideas were recorded.

Phase 2: Generating Initial Codes

Coding is the bridge between the collection of data and the identification of themes, referring to the way that researchers divide the data into varying sized portions, depending on ascribed meanings and relevancy to the research aim and which are then labelled accordingly (Saldana, 2013). This phase is similar to grounded theory's initial, or open coding and because thematic analysis does not provide detailed guidelines for this phase, Floersh et al (2010) stressed the importance of the researcher providing a clear description of the strategies implemented at this stage.

I carried out line-by-line coding manually and the data was grouped according to data set, starting with the observational data, followed by the interviews with the asylum seekers including the cultural mediators and then the HCPs. The constricted focus that line-by-line coding provided helped to minimise the formation of rigid assumptions, which at such an early stage could have hindered the emergence of other, equally important concepts (Rapley, 2011). Initially, my coding was littered with descriptive labels representing the tangible content but as I progressed, patterns began to emerge leading to the grouping of similar items that were then assigned with expanded labels, to represent the data placed in each code. By the end of this phase the data was assigned to six main groups, namely migration, communication, asylum seeker health, healthcare utilisation, healthcare provision and general/miscellaneous issues but was still being separately coded according to whether the data was collated from asylum seekers, cultural mediators, or HCPs.

Phase 3, 4 & 5: Searching for, Reviewing, Defining and Naming Themes

These three phases, as outlined in Braun & Clarke's (2006) analytic model, represent the strategies that lead to the formation of themes which represent the salient content and meaning of the data in relation to the research question. This part of the process started with a review of the codes and an initial identification of "candidate themes" (p 92) that were formed following an examination of the relationships between these codes. Once the initial themes are identified, the relationships between these need to be explored for "internal homogeneity and external homogeneity" (Patton, 2002, p 465), as advocated by Braun & Clarke. I therefore examined whether these themes were clearly distinct from each other but at the same time complemented each other to provide a coherent and holistic picture of the data. At the end of this process, I first developed three thematic maps as a visual representation of the themes that had been identified in both interview groups and observation (Braun & Clarke, 2012). This was followed by a review of the themes in relation to the original codes and further revisions were required to delineate meaningful boundaries and achieve coherence. By this stage, I felt that the thematic maps were an honest representation of both manifest and latent contents of the data and following a consideration of the themes of the three data sets, these were incorporated in one thematic map, with 'seeking' emerging as the overarching theme.

In conformity with research guidelines as dictated by critical ethnography and a postcolonial stance, reflexivity was carried out throughout the above process with a continuous examination of how I was influencing the data analysis, in an attempt to ensure that the resultant findings are an honest representation of the participants' experiences (Angrosino, 2007).

Ethical Considerations

The theoretical and practical aspects of ethical considerations permeate throughout the phases of the research process and this is evidenced in the discussions related to ethical issues that have been addressed above. These dilemmas appear to be numerous when carrying out research with 'non-Western' populations and possibly even more so, when the

research specifically addresses asylum seekers, which requires the researcher to critically address issues such as informed consent and the use of ethical approaches that are based on ‘western’ assumptions and participant risk.

Ethical Approval

Prior to the initiation of data collection, ethical approval for this study was acquired from the University Research Ethics Committee, Malta and the Health and Life Sciences Faculty Research Ethics Committee, De Montfort University, UK. Approval for access to the data collection field was granted by the Data Protection Officer, Primary Health Care and the Nursing Officers in charge of the two health centres.

Measures to Ensure Confidentiality

As evident in the PIS and consent forms, the participants were assured of full confidentiality through the following security measures. All data in hard copy form, were securely stored in locked drawers, to which only I had access. This data included the field notes and audio tapes from the interviews and personal identity information. Prior to storage, personal identity information was coded and stored separately from the collected data. The key linking codes and consent forms were also stored separately in a locked cabinet. Computerised data was stored on my personal computer and an external hard drive and the latter was kept in a locked cabinet when not in use. Additionally, both of these were password protected. Further to this, the findings were anonymised, which, because of Malta’s small size, posed an especial challenge and as a result, some data was purposely excluded. Pseudonyms have been used for all the participants throughout the thesis.

Informed Consent

As mentioned above, informed consent is complex and increasingly so in relation to asylum seekers and refugees because of a potential dissonance between these population groups and the assumptions underlying informed consent (Hugman, Bartolomei & Pittaway, 2011). Indeed, the literature is replete with arguments that question the

appropriateness of utilising research ethic frameworks that are based on ‘Westernised’ assumptions (Adu-Gyamfi, 2015; Ellis, Mia-Keating, Yusuf, Lincoln & Nur, 2007; Mackenzie, McDowell & Pittaway, 2007; Wong-Kim & Song, 2007), within an environment synonymised by power inequities (Coleman, 2009; Zion, Briskman & Loff, 2010) and participant vulnerabilities resulting from situational sociopolitical forces (Rousseau & Kirmayer, 2010). Despite this, ‘Western’ research ethic review boards generally tend to utilise a “checklist approach” (Adu-Gyamfi, p 44) and lack the necessary expertise to ensure that their stipulated conditions for ethical approval of a proposed research study are culturally-appropriate, with the resultant potential for these conditions to cause the very harm that they are trying to avoid (Dawson & Kass, 2005; Ellis et al).

Ellis et al (2007) highlighted a number of problems directly related to obtaining written informed consent in research with refugees and further questioned the ethical validity of utilising written informed consent procedures in these circumstances. These problems include: situations when the participants’ worldviews do not encompass individual autonomy and decision-making that are the values upon which informed consent is based; diverse understandings of voluntary participation, especially in view of the power imbalances at play and even more so for those participants who have experienced a tyrannical past; acceptance to participate because of fears of negative repercussions, or the unfounded belief that this would be repaid with a desired reward; and finally, the inappropriateness of asking for written consent, which could cause great distress. During my observational data collection, the above-mentioned problems were, in my view, amplified by the requirements and restrictions that were placed upon me and that were conditional to ethical approval of this study.

I am registered for my PhD studies with De Montfort University (DMU), Leicester, UK, sponsored by the University of Malta (UOM) and all data collection was carried out in Malta. As a result of this, I was required to get ethical approval for my study from both DMU and UOM ethical review boards. For approval to be obtained, extensive information needed to be included in the PIS (Appendix 3), which as can be seen, ended up being three pages long. This runs contrary to recommendations that emerged from a study that utilised community contacts to develop appropriate recruitment information sheets, with the

participants emphasising the importance of information sheets being short and simple, further explaining that within one individual, spoken and reading fluency is highly variable (Renert, Russell-Mayhew & Arthur, 2013). The validity of these observations was clearly demonstrated by one of the cultural mediators participating in the present study who spoke English fluently and with whom I had spent a long time explaining the study, was present as he carefully read the PIS and answered any further questions that he had. Despite this, I realised that he had not understood the information fully, when he introduced me to potential participants and included some incorrect details in this introduction. This corroborates Czymoniewicz-Klippel, Brijnath & Crockett's (2010) claims of the challenges associated with abiding by the conditions as set down by ethic review boards in complex and culturally diverse research relationships, with these authors further concluding that in specific circumstances such as low literacy, written information might be inappropriate.

The practice of asking all research participants to sign consent forms indiscriminately, with no attention paid to contextual variations, has also been criticised (Adu-Gyamfi, 2015; Birman, 2006; Czymoniewicz et al, 2010; Ellis et al, 2007). Birman asserted that this practice with culturally-diverse participants does not only negate prior declarations and promises of anonymity but, as a result of review board requirements, these forms are often unwieldy and have been found to cause undue distress. Indeed, Ellis et al questions whether the practice of signed consent serves mainly to protect the researcher to the detriment of the researched. At the time that I applied for ethical approval in 2012, the specifications for informed consent as laid out by the DMU Health and Life Sciences Faculty Research Ethics Committee required that the participants sign their initials against each issue raised on the form, of which there were 12 and this was then followed with their full signature (Appendix 2). Although there were no asylum seekers who refused to sign these consent forms, I could not but wonder whether they were totally comfortable with signing these forms and whether they had agreed to this because they did not feel that they had any other option, despite my assertions that their participation was totally voluntary. Furthermore, the fact that the management required that I wear a lab coat and tag whenever I was carrying out observational data collection, very possibly added to images of me being an authoritative figure and further impacted on the asylum seekers'

notions of a lack of true choice in relation to their participation, irrespective of their consent being sought.

Guidelines developed by the European Commission, Director-General for Research & Innovation (2016) on research with refugees, asylum seekers and migrants identified alternative strategies to written consent forms and these included obtaining oral consent and referring to a cultural insider throughout the processes leading to informed consent. Whilst obtaining oral consent was not an option for me, I discussed these issues with a number of professionals who work directly with asylum seekers, including cultural mediators and I sought and heeded their advice on approaches that could in any way minimise the above-mentioned drawbacks. The importance of trustbuilding as opposed to being asked to sign a consent form on one occasion, has been highlighted in a study that examined Portuguese Canadian and Jamaican Canadian immigrants' perspectives of informed consent for research purposes (Barata, Gucciardi, Ahmad & Stewart, 2006) but because of the nature of my observational data collection, this approach was actuated with the HCPs but was beyond what could be achieved with the asylum seekers, as dictated by the nature of the data collection strategies.

Participant Risk

The potential risks to the participant were related to both psychological and social issues, with one of the major risks being the potential disclosure of the participants' identity with its resultant repercussions and this has been addressed above.

I attempted to avoid duplicitous behaviour and ensured that participants were continuously reminded of my role as researcher and thereby guaranteed that all recorded data had been consciously consented to. Because of the potentially intrusive nature of observational research, the participants were informed that they had the option to ask me to withdraw from a clinical observation session at any time and I was vigilant to do so unbidden, when there was an indication that the participants were experiencing any discomfort, embarrassment, or anxiety by my presence. Incidentally, throughout the observational data collection, I only felt the need to withdraw from one encounter.

Whilst both healthcare professionals and asylum seekers had similar roles as participants of this research and were treated with equal sensitivity and respect, one cannot ignore the fact that the past traumas that the asylum seekers suffered and the present challenges that they face, could have rendered them vulnerable, as could the power relations at play (Werbner, 2002). Whilst I kept this in mind throughout, any of the referrals or advice that I felt I should give was related to diverse aspects of service utilisation. Lastly, all participants were provided with my email address and asked to contact me, if they would like me to provide them with a report containing a summary of the findings.

Critical Ethnography, Postcolonial Research and Ethics

Gonzalez (2003), claimed that the ethics of postcolonial research is based on the concepts of accountability, context, truthfulness and community. These interrelated concepts refer to taking responsibility for the knowledge that we produce, ensuring that it provides an honest representation through a clarification of the context and in full awareness of the audience that we are trying to reach (Gonzalez). Hammersley and Atkinson (2007) similarly claimed that the presentation of “true accounts of social phenomena” (p 209) is the goal of ethnography and therefore, research that produces these “true accounts” can generally be justified on an ethical level. Notwithstanding this, these authors further argued that despite the benefits of research that produces true knowledge, other ethical considerations need to be addressed.

Anderson (2011) stated that the production of knowledge could be considered as a “form of sorcery”, as researchers concoct knowledge drawn from various aspects of a person’s life and simultaneously do not need to adhere to the social norms of regular relationships. Postcolonial research requires researchers to question their motivation for carrying out the research and the audience that it aims to reach (Alcoff, 1991 – 1992); their own complicity in colonialist practices and their ability to produce an honest representation of the data (McKeever, 2000); and to ensure that their accounts do not reinforce the colonialist mentality that they are attempting to reveal (Westwood, 2004). Reference to these issues in relation to the present study is provided throughout the thesis whenever pertinent.

Establishing Credibility

The debates in relation to strategies for establishing rigour in qualitative research appear to lack consensus, evidenced in the abundance of terms that refer to identical concepts and that suffer from a “lack of clarity” (Morse, Barrett, Mayan, Olson & Spiers, 2002, p 15). This lack of consensus on the one hand presents arguments stating that adapted versions of the quantitative criteria of validity and reliability could and should, be used to establish rigour in a qualitative study (Beverland & Lindgreen, 2010; Morse et al). On the other hand there is the belief that totally different criteria are required to establish “goodness”, credibility”, or “trustworthiness” in qualitative research (Cohen & Crabtree, 2008; Noble & Smith, 2015; Tracey, 2010), based on the research paradigm, the aim of the research and the researchers’ and participants’ philosophical viewpoint (Northcote, 2012). For the purpose of this study, “trustworthiness” was established by implementing strategies that have been proposed in the literature, guided by criteria established by Lincoln and Guba (1985) and as proposed by Noble & Smith. The criteria are truth value, consistency, neutrality and applicability.

Truth Value

This criterion relates to representation in recognition of the unavoidable influence that the researcher has on the generation of knowledge. In view of this, I attempted to be reflexive throughout all the phases of the research process and further documented decisions taken, together with the reasons underlying these decisions. These instances are evident throughout this chapter and corroborate Morse et al’s (2002) assertions that strategies to ensure a study’s rigour have to be implemented throughout the process. Other suggested strategies to reveal any hidden biases include peer review and throughout the research process I discussed salient issues with professionals who work directly with asylum seekers, including the cultural mediators. Moreover, I attended and participated in a number of related seminars and workshops that encouraged and enabled self-awareness through group activities and discussion. Additionally, the combination of observation and interviews with asylum seekers, cultural mediators and HCPs enabled a triangulated and holistic view of healthcare utilisation and provision and produced an account that is

representative of the participants' voices, as evidenced by the numerous exemplars included in the findings.

Consistency

Consistency is the evidence that shows that the various measures taken throughout the research process are appropriate and this can be achieved through meticulous note-taking that would be valuable as an audit trail. This chapter discussed the various measures taken during the study and the reasons underlying these, some of which were a choice and others determined by uncontrollable factors, such as a realisation of participant discomfort. As mentioned previously, this situation occurred in my original recruitment plan for interviews with asylum seekers and whilst this possibly resulted in some limitations in relation to sample population, I felt that the principle of "do no harm", far outweighed any other considerations. Consistency also guides one to question the appropriateness of the research design utilised in relation to the research question and the rationale underlying my choice is provided above.

Neutrality

Neutrality is the degree to which the researcher has remained true to the data and a description of the thought processes involved in the thematic analysis that was carried out during this study is provided above.

Applicability

This last criterion is related to whether the conclusions of this study can be applied elsewhere and is reliant on the provision of rich contextual detail and a holistic image has been provided in this thesis, not only in relation to the issues related to the PHC setting but on a broader national scale.

Limitations

One of the main limitations of this study is related to the recruitment of asylum seekers for the interviews. As described in chapter three, despite having originally planned to recruit these from the observational sessions, the plan had to be abandoned. This meant that at times I was unable to clarify and delve further into certain issues that I had observed with the person who had been directly involved. I attempted to minimise this limitation by discussing the situation with the cultural mediator if he was present and by including these issues in my interview schedule.

Another limitation with regard to recruitment for the interviews was that all the asylum seekers whom I interviewed were receiving some form of support and therefore one need acknowledge the probability of this study's failure to access "hidden" subgroups, who have been rendered invisible through marginalising practices (Ellard-Gray, Jeffrey, Choubak & Crann, 2015) and who consequently face more obstacles in relation to good health and healthcare access, utilisation and provision. This limits the width and applicability of the study's findings due to this group's exclusion and consequent lack of representation (Sydor, 2013). Notwithstanding this, a number of asylum seekers were recruited as interview participants through an NGO and these types of organisations have been cited as well positioned in relation to their exposure to "hard to reach" populations (Flanagan & Hancock, 2010, n.p.).

A further limitation of this study is related to voice representation and as discussed in a previous section, it is undeniable that my own positionality in relation to the participants impacted on representation. Notwithstanding this, being informed by a postcolonial perspective enabled me to become sensitised to issues related to power relations and 'Othering' practices and utilised specific strategies throughout the research process as described above, in an attempt to minimise this impact.

Conclusion

This chapter firstly presented the underlying methodology by discussing the rationale for choosing critical ethnography to guide this study and by illustrating the benefits of using a postcolonial lens to explore cross-cultural healthcare utilisation and provision. A study that is guided by critical ethnography through a postcolonial perspective enables the researcher to develop a conceptual understanding that challenges essentialist discourses of ‘race’, ethnicity and culture, allowing for a critical examination of the constructions of social identities through ‘Western’ assumptions, which have the potential to legitimise current inequalities in health care. In the current climate of globalisation and a local governmental and populist discourse of exclusion, the utilisation of a critical ethnographic approach guided by a postcolonial perspective was deemed to be highly appropriate, in an attempt to discover health care experiences of asylum seekers and HCPs in the PHC setting, within a context that addresses the influence of old and new forms of imperialism and in consideration of various sociocultural forces.

The ensuing detailed method section not only provided essential information regarding the various research strategies utilised throughout this study, but further highlighted numerous issues with both practical and ethical implications, which whilst common to all research projects, were amplified as a consequence of conducting research with asylum seekers. The ‘trustworthiness’ and limitations of the present study were also discussed.

The following three chapters will present the findings that emerged from the data collated through observation, informal conversations and in-depth interviews.

Chapter 4: Seeking Refuge and Beyond - The Migratory Process

Introduction

The next three chapters present the findings through three themes, deduced from the different forms of data sets simultaneously. These three themes and their respective sub-themes as identified in Table 6, are a representation of asylum seekers' and healthcare professionals' (HCPs) experiences of cross-cultural healthcare encounters and illustrate the array of issues that impact these encounters in both a direct and indirect manner.

Table 6 Themes and Sub-themes

| Themes | Sub-themes |
|--|--|
| 1. Seeking Refuge & Beyond: The migratory journey | <ul style="list-style-type: none">• The long & perilous journey• Life on hold• Life on the edge• Physical & psychological scarring• Through the eyes of the HCPs |
| 2. Seeking Mutual Understanding: communicating within the healthcare encounter | <ul style="list-style-type: none">• Linguistic discordance• Its not just the language• Mistrust & misunderstanding• Power differentials & control |
| 3. Seeking Resolution | <ul style="list-style-type: none">• Finding the way• Providing care• Needing support |

The data for this study was collated through an observational period of healthcare encounters in the Health Centres, as well as through in-depth interviews and informal conversations with both asylum seekers and healthcare professionals, namely doctors and nurses. Therefore, in the presentation of these findings, when the word 'participants' is

used, this refers to both asylum seekers and healthcare professionals together. Anonymity has been ensured by the use of pseudonyms for those participants who have been interviewed, while the initials IC which follow the testimony of other participants, indicate that the data has been collated through informal conversations. In these latter instances, the participant's status namely: asylum seeker (AS), Nurse, or Doctor will also be included.

This chapter will present the findings in relation to the first theme that addresses the asylum seekers' migratory process through the five sub-themes that have emerged from the data. These are entitled "The long and perilous journey"; "Life on hold"; "Life on the edge"; "Physical and psychological scarring" and "Through the eyes of the healthcare professionals". The asylum seekers' previous lives, as well as the reasons that they gave for leaving their homeland, were varied, ranging from war and persecution, to abusive relationships, deprivation, or a search for a better life. Irrespective of the reasons underlying their escape, the asylum seekers' accounts of the ensuing journey made their suffering and their responses to this suffering visible, through their stories of loss, betrayal and extreme hardship. These experiences have helped shape who they are now and the way that they interpret and respond to various situations, including healthcare encounters.

The Long and Perilous Journey

The asylum seeker is not one type of person, with one type of past. The asylum seeker is Akram, who used to work in a library for three or four years before leaving Iraq in 2005 for his five-year journey to Malta. The asylum seeker is also Amiir, who was a mechanic in Mogadishu, or Ndidi who was forced to marry a 70 year old man when she was just 14 years old in Lagos, or Daleel who before his accident worked in his own business, after having achieved a diploma in business administration.

Daleel's accident occurred when he was running away from Mogadishu and he had to spend some time in a hospital in Kenya with a head injury and subsequent mental health problems. Despite this, he continued on his journey through Sudan and Libya and then onto Malta. This route was similar to Ali's, whom I met during one of my observational periods. Ali had travelled to Sudan from Eritrea in 2011 to escape what he described as

unwarranted imprisonment. He recounted his long journey, which showed similarities in relation to the extreme hardship faced by other asylum seekers:

I escaped to Sudan and lived in a refugee camp, with thousands of other refugees ... it was very difficult and very dangerous to live there and after 2 years I received money from my family and paid some men to take me to Khartoum. We were in a truck for 14 days with no food and little water till we arrived in Tripoli (AS; IC)

Despite the hard journey across the Sahara, Ali still considered himself to be one of the lucky ones for having survived when so many other asylum seekers had died in the desert. Although according to him it was more than luck as he ascribed his survival to “*Allah’s*” divine intervention. Ali further described the one-year that he spent in Tripoli, as one that was monopolized by the fear of being captured by the Libyan militia. Again he said that it was divine intervention that enabled him to escape capture and this belief appeared to give him a sense of hope, as he saw this as a sign that “*Allah*” had a greater plan for him. Some of the other asylum seekers also demonstrated similar convictions, such as Simret who had a belief in God’s plan and claimed, “*everything is from God*”, whether the event was good or bad. Indeed, when he was describing how he and his family were rejected for resettlement to the USA, despite showing his disappointment, he added the words “*believe me, this is from God*”. This seemed to provide him with some form of comfort in the conviction that the rejection was for a greater good and he further added that it showed him that after all “*Malta is better than America*”, despite him and his family’s strong desire to go to the USA.

It is not all the asylum seekers who credited a God for all that had happened and for these, irrespective of the passing of time, the struggle to give meaning to all the suffering still lingered: “*When I remember certain horrible things I ask why and how ... but I cannot find the answer, so the best is not to think ... to try to forget ...*” (Ndidi). In this quotation, Ndidi was referring to all the horrors and humiliation that she had to face in Libya, where she was forced into prostitution. Humiliation was also evident in the testimonies of those asylum seekers who were detained by the Libyan militia and who provided vivid descriptions of beatings and various other forms of torture: “*They used to keep us locked*

up and would beat us and they would also shoot at anyone who would try to escape ... I never did, I was too afraid ... ” (Amiir)

When I arrived in Libya they caught me and when we were in detention the guard took me and raped me ... the other women they tried to stop him but it was no use”
(Maryan)

Eventually, all the asylum seekers who were interviewed boarded boats and embarked on the dangerous journey across the Mediterranean Sea. When I asked them whether they had considered the dangers of this journey, they said that they obviously knew of the risks but felt that they had no choice but to get on the boat as their only chance of survival:

Of course you know and think about this but it is very simple, you have no choice ... you cannot go back, you cannot stay there, what can you do? So yes, of course I was afraid but also a little bit excited (Patrick)

Another Eritrean man, who I had met during the observational period, highlighted the horror of his boat journey, when after five days at sea on an overcrowded boat with no food supplies left and dwindling water, a fight broke out and a man was stabbed and killed and ended up being yet another dead body in the Mediterranean sea. Just one day later, the man who recounted this story arrived in Malta and like all the other ‘boat people’, was placed in closed detention³.

Baba, an asylum seeker from Mali, vividly describes his initial impressions of the Maltese peoples’ attitude towards asylum seekers:

We could not keep the water out of the boat and the Maltese soldiers saved us from the sea. All the soldiers, they wear big white coats with hoods on their heads ... big boots, gloves and those things covering their face ... it was like they come from the

³ As mentioned in the introductory chapter, a new migration strategy for Malta was introduced in December 2015, which states that asylum seekers will no longer be detained automatically and that the decision is dependent on pre-established criteria (Ministry for Home Affairs and National Security, 2015)

sky. But no, it is because they say Africans are full of dirt and illness. I say thank you for saving me but we do not carry disease. (Baba)

Life on Hold

All the asylum seekers who were interviewed had not intended to come to Malta but had planned to land in Italy and then continue their journey to the prosperous European countries further north. They had ended up in Malta, either believing that the island was Italy, or because they were rescued in Maltese waters following some form of trouble with the boat they were on. Once in Malta they had all been placed in closed detention, ranging from a period of five to eighteen months. It was only Caadil who had anything positive to say about this experience: *“I stayed there 8 months, they give us a good welcome. They give us everything we need. They give us good accommodation ... I have no problem because they give us all the things that we need.”*

At the time of the interview, Caadil was waiting to be transferred to the USA following his successful application for resettlement and this positive outcome could have possibly either influenced his perception of his past experiences of the migratory journey, or made him loath to appear ungrateful. The other asylum seekers all spoke of the frustration of them having survived the treacherous journey and finally arriving in Europe, only to be locked up in cramped quarters for months on end, having absolutely nothing to do but wait for an answer to their request for refugee status. Baba talks about the injustice and consequences of closed detention:

I ran away from my country for my dear life and they saved me ... only to treat me badly. Everyone is placed in detention ... is this giving people freedom? To throw people into detention together and then you tell them not to disturb? I get very angry and so I keep myself away from everyone. (Baba)

Apart from a few isolated, short projects by nongovernmental organisations, during the period of data collection no formal educational, or information sessions, were provided for the asylum seekers whilst they were in closed detention. Notwithstanding this, Akram, who

speaks Arabic, decided to use this time in detention to learn Maltese and he can now understand and speak Maltese proficiently⁴:

I spent nearly a year and a half in detention and so I started doing something useful. I used to get Maltese books and I used to learn ... yes, I spent nearly one year studying. I had a few books in Arabic that were translated into Maltese and Maltese translated into Arabic and I used to read these and try to understand.
(Akram)

Apart from learning Maltese, Akram reported that he did not learn anything else whilst in detention and only got to know about available services and the way that they functioned, once that he had left detention:

We were new to Malta when we were thrown in detention and till I came out of detention, I didn't know about Malta. It was when I go out in the community that I learn about the services and the systems of these. (Akram)

Indeed, when I asked the asylum seekers where they had learnt how to access the health services, it was only one of them who told me they had learnt this from other migrants when they were in closed detention: “*When I was in the detention, they mentioned that if you need for primary health care, you can go to (name of Clinic) Health Centre*” (Sabo). The majority learnt about the various available services once they had been released from closed detention into the Open Centres and their testimonies give the impression that the time spent in closed detention was one of disillusionment and despair as they waited to get on with their lives, which had once again been suspended. An asylum seeker whom I had met during observation and who had just been released from detention the day before said:

You spend years travelling to escape death ... you leave your family and the ones you love ... you risk your life over and over again and then you arrive in Europe but still you cannot start to try to put your new life together because you are made

⁴ Maltese is a Semitic language and there are some similarities between Maltese and Arabic, although Maltese is written in Latin script.

a prisoner again. I was locked up for 11 months and I can't understand why ...
(AS, IC)

When asylum seekers who are in detention are taken to a public place, such as a healthcare clinic, they are handcuffed and accompanied by security guards. This possibly serves to further exacerbate public opinion of asylum seekers as being 'illegal' and encourages the use of terms such as 'illegal immigrants' and 'clandestines' that are commonly utilised locally when referring to these migrants. Nkem talked about the humiliation of appearing to be a criminal because of being handcuffed:

Oh it was so bad from the detention, when they take me to hospital and I have the handcuff over my hand, it is very bad ... because we are like criminals ... the people they are all looking at us and doing this (she pulls a distasteful face) ... "look they are criminals!" ... We are not criminals! (Nkem)

In addition to the humiliation and negative impact on the public's perception of asylum seekers, the fact that security guards accompany them is a cause for further trouble with the host population. As a nurse in one of the specialist clinics that I observed explained:

Because they come with the guards, I let them skip the queue, only out of respect for the guards you know because they would need to get back as quickly as possible... but when this happens, all the other people waiting start complaining and shouting because they cannot accept that a migrant should be jumping the queue (AS, IC)

The majority of the Maltese view asylum seekers as a burden and further feel that the support that they are presently being provided with is already beyond Malta's means and limits. Therefore what they view as any other concessions, however small, such as skipping queues, seem to be viewed as the last straw. In fact, whilst unrelated to detention, one of the nurses who was interviewed said that these complaints also occurred when a black person would possibly arrive at a Health Centre as an emergency and therefore would jump the queue. At this stage it would be pertinent to add that for the majority of the Maltese, any black person is automatically presumed to be an asylum seeker and

throughout most of the healthcare providers' interviews, the word black was used interchangeably with asylum seeker and migrant. The above-mentioned nurse said:

... For example someone comes in as an emergency ... that is if you, a Maltese person came for the treatment room and a black person came as an emergency and I am going to take him in before you ... the Maltese explode in that situation ... they explode because they say "damn it! These! I am in my own country and yet this one is going to be seen before me?" (Mark)

Further to this, another nurse said that some of the Maltese even expected to be seen before the asylum seekers, irrespective of who was there first: *"At times some people say, the people who are in the waiting room that is ... they pass a comment, or they expect to go in before them ... the Maltese first because they're Maltese sort of thing"* (Miriam)

As these last two quotations indicate, there is a general attitude of "Us" and "Them" amongst the Maltese population and the consequences of this is evident in the upcoming section with findings that show how a release from detention would not result in an end to the asylum seekers' segregation and marginalisation.

Life on the Edge

Once the asylum seekers were released from detention they were placed in one of the Open Centres, which appeared to have provided some of the asylum seekers with a sense of community. As Amiir explained:

When I go to the Open Centre, I met a lot of other people from Somalia and other African countries. They helped me to know what to do and to find out about Malta. Now I am in a flat with some of these people that I met in the Open Centre. (Amiir)

Similarly, Patrick, who was living in an Open Centre during the time of the interview, appreciated being surrounded and getting support from the other African residents and staff. Although in Patrick's case, he was placed in an Open Centre on discharge from the

psychiatric hospital, where he was admitted after having lived on his own for a substantial period of time:

Its been a long time that I have been with a lot of Africans like this, so I am happy ... Now I am getting stronger again and here I have the support of the social workers and care workers and so I am very pleased to be here ... I am still learning some other things from people here ... yes ... (Patrick)

Contrary to Amiir's and Patrick's positive reactions and according to Habiba, a Libyan woman that I had met during observations, the fact that in the Open Centres one can socialise with other asylum seekers who are of a different nationality to one's own, is a potential source of great distress to Libyans. Habiba had come to the Health Centre to act as translator for another Libyan woman who could barely speak any English. She explained how till only a couple of years back, Libyans were living a good life in Libya, especially Tripoli and would feel very superior to Africans, who were refugees. Because of this, those Libyans who were living in Open Centres were finding it very hard to accept that they had to share living space with Sub-Saharan Africans and could not bring themselves to socialise with them. It is pertinent to point out at this stage that at no time did Habiba refer to herself, or other Libyans as Africans and it was very evident that she did not consider Libyans to be so. Habiba further lamented that because forced migration of Libyans to Malta was, at the time of our conversation, a relatively new phenomenon, a proper Libyan community in Malta had not as yet been established and therefore there were large numbers of Libyan asylum seekers who were isolated with very little support, if any⁵.

Despite not being Libyan, Simret also appeared to have had problems with other residents, as well as the administration when he was in an Open Centre with his family, with conflicts arising mainly from issues related to his childrens' needs. They were accommodated in an Open Centre after they were caught living illegally in Norway and sent back to Malta. Simret appeared to feel that he was responsible for this rejection by the

⁵ The rise of Libyans seeking asylum in Malta began in 2014 and since then, they have become the largest group of non-boat arrivals to apply for asylum (UNHCR, 2016a & 2016b).

Norwegian authorities and the situation that he and his family were in and that his main role was to ensure their wellbeing:

So I came here in (Name of Open Centre) ... you know ... and I lived in a container around 7 months and the problem you know, more than 5 months without school. My son so sometimes he shouts “ why we coming here? I’m not blaming you but ...”. Anyhow we stay here and I am fighting you know with the fathers ... with the refugee offices ... I need school. I have 5 children, the last one he was born in Norway, so until they go to school ... 5 months! (Simret)

For Simret, having dependents seemed to result in added pressure for him to succeed and in so doing, to be able to provide sufficiently for his large family. As he himself said:

I have too much problem ... I am really not treated like a king in my house ... no ... I have to fight 24 hours ... this one he wants something, this one he wants money to put in his mobile phone, this one he wants to go with his friends ... many, many things all the time ... and after we get rejected from the US, this one he shouts the biggest you know ... (Simret)

That his family would come to no harm was another obligation that Simret felt was his sole responsibility: “*I have to first take care of my family and then second, I would have to take care about myself*”. This was also an issue for Maryan, who at the time of the interview was living in an Open Centre and was very concerned because she felt that the environment was far from amenable for her 6-week-old baby girl:

I need to find a place to live because that place is no good ... there are many people and it is not clean ... a baby needs a clean and quiet place ... I try but it is impossible to do that there. I don’t know what to do ... but it will be much worse if they send me back ... (Maryan)

Maryan’s desperation was further heightened by her rejected status, which at the time of the interview, was under appeal. Two of the other rejected asylum seekers that I had

interviewed were unsuccessful in their appeals and a lot of their time since this final rejection, was spent wondering when they were going to be repatriated:

I don't know when they will come to send me back ... I don't have any hope ... The Refugee Commission think that I have lied to them... They say that they are Christians ... in fact, everywhere you go there are sacred things ... but this does not make them good ... they're not good ... I never see a sign of help (Baba)

The other asylum seekers' testimonies did not exude this sense of total hopelessness but their words did echo an uncertainty caused by the temporary protection that they had been granted, which at the time of the interviews was subject to an annual review. For most of these migrants, the review served to add more insecurity to an already precarious life:

Even though all things remain the same and so it is no problem to renew my subsidiary protection, I am worried when I renew it. It is very easy ... you just go to the office and they say that all is good and then, when they tell you, you go back to pick up the new one ... but still you always say, "what if there will be a problem? What if they say no? (Ndid)

This sense of impermanence was further exacerbated by the fact that none of these asylum seekers had initially planned to come to Malta and the majority of them seemed to be waiting for any opportunity to go to mainland Europe or the USA. At the time of the interviews, two of the migrants were scheduled for resettlement in the USA following their successful application and another two had been sent back to Malta after they were caught living illegally in Scandinavian countries. This wish to leave Malta is often linked to the limited opportunities for employment and career advancement because of its small size⁶. Ouma, a qualified interpreter from Senegal explained:

⁶ Since 2016, following a shift in European migratory entry routes, the situation seems to be changing, with a small number of asylum seekers caught flying to Malta from other European countries with false passports, reporting that they have come here to find work because of Malta's low unemployment rate ("Ghanian reprimanded for entering Malta with fake passport", 2016)

Over here it is very difficult to find good work ... I have studied and I speak many languages and still it is only in the supermarket that I find full-time work. I cannot live on only part-time in interpretation and so I stop this and go to fill shelves full-time instead ... I don't like it but ... (Ouma)

One of the nurses whom I had interviewed corroborated this as she spoke about asylum seekers she had befriended when she used to work in another setting: *"when I was in (name of area), we had some cleaners who were asylum seekers and I used to ask them questions about themselves and their culture and they would actually be academic achievers and here they find themselves in cleaning jobs!"* (Carmen)

The pressure to be employed and thereby financially secure was not only of special importance to those migrants who had dependents here in Malta, such as Simret, who recounted how he begged the surgeon to give him an early appointment for an operation that would enable him to go back to work: *"I tell him "I want to work, I have a big family, nobody will take care of them except for me. Please do something".* This pressure was equally felt by Jamaal, who is Somalian and a qualified interpreter and whose wife and 3 children were at the time of the interview, living in Kenya and whom he used to send money to. When I met Jamaal, he was working part-time on a funded project but this was a temporary appointment and he was very worried that when it was over he might not find another job and would be unable to uphold his responsibilities towards his family. Ali, whose escape from Eritrea is recounted above, spoke about the shame in the eventuality that he would not succeed in finding a job and would have to return home with nothing, especially after his family had financially supported his escape:

Two times my father send me money ... when I was in Sudan and when I was in Libya. He collected this money from his brothers and other family and if I go back to Eritrea with nothing, for me, facing the family would be a bigger problem then the problem of being caught and in prison. How can I look at them in the face if I am a failure? (Ali, IC)

Ouma spoke about the financial demands that his parents and the extended family back in Senegal made on him, demands which he found overwhelming: *“My father tells me that my cousin has problems and needs money and then my other uncle has a problem and then ... it just keeps on going ... too much!”*

Unemployment appeared to exacerbate the asylum seekers’ marginalisation and segregation that in turn, further compounded the feelings of impermanence mentioned previously, with minimal opportunities for the asylum seekers to socialise outside of their own communities. When I asked them whether they socialised with other people who were not Africans, the people who they generally mentioned were those who worked at either the Open Centres, or with nongovernmental organisations (NGOs) from whom they were getting some form of support:

I am friends with (name of staff member) and (name of staff member) here in the Centre. They make my appointments with the doctor and tell me where to go when I have the appointment, (name of staff member) helps me to take my pills. They are very good and we are even facebook friends (Daleel)

For Nkem, one of the people who works in an NGO has provided her with so much security and comfort that she considered this person to be like a mother to her:

When I have a problem, she know about it ... I tell her and I start crying and she said “don’t worry, everything will be okay.” She kept saying “don’t worry, everything will be okay.” She is just like my mother so ... She is lovely, she does a lot of work. Yes, she’s just like my mother (Nkem)

Apart from these instances of professional relationships, the asylum seekers that I interviewed, both those who lived in the open centres and those living in the community, did not appear to have opportunities to meet or socialise with Maltese, or other non-Africans. One of the nurses whom I interviewed claimed that the segregation was tangible and further described how she had perceived asylum seekers being ostracised even on buses:

I notice ... all these people they just keep on walking past. Often the bus will be full up and they do not sit next to ... yes, I think it is really disrespectful! So often I go up and sit next to them, not because I want to sit in that place particularly but because ... how can I put it? So that they ... yes, I feel so awkward seeing the other people do that, so my action is a way of saying "excuse us, we are not all like that". Yes, I often do that (Carmen)

On the other hand, two of the other nurses interviewed did not feel that the people in waiting rooms at the Health Centres avoided sitting next to black migrants but despite this, one of them did claim that there still appeared to be a reluctance on the part of the Maltese to strike up a conversation with the asylum seekers:

Whilst I haven't notice Maltese keeping their distance in the waiting room, neither have I seen anyone striking up a conversation with them ... it could be for example to strike up a conversation with them is more difficult than to strike one up with a Maltese. You're not going to ... Oh I don't know! With them you seem to find it more difficult ... (Mark)

The situation appeared to be different for those asylum seekers who worked and the majority of the healthcare professionals who were interviewed spoke about working, or having worked, with asylum seekers saying that after a while, these were generally considered to be part of the team. Notwithstanding this, the ways in which the HCPs explained these situations seemed to indicate that the interactions did not happen automatically but required a conscious effort on their part and further provided narratives that illustrated how cultural mediators are still viewed as the 'Other' by the HCPs. Two examples of this are given in the following quotes, where these two nurses were referring to the same African cultural mediator who worked at the Health Centre with them:

He is very educated, even with us and ... when we are eating at table we tell him, "come near us", do you understand? And then he joins us but he still feels a bit uncomfortable. ... but he is very grateful and now it is as though he is one of us you

know and he interacts ... he is very helpful ... we see him as being very nice
(Joseph)

Last time we received a box of chocolates and we opened it and the charge nurse told me to share it amongst everyone ... and I didn't feel I shouldn't give him and I told him "take one because you are a member of our staff also" ... he was happy and the patients who were waiting there, were all looking at me in a bad way ... and that made me feel even better "here, have another one" ... because he is really nice with us (Maria)

Work does not only provide an opportunity for asylum seekers to meet locals and people from other countries but according to Patrick, work had helped him to retain his sanity by not allowing him the time to think too much, which he believed prevented his readmission to the psychiatric hospital. The impression that too much thinking was a cause of mental illness seemed to be a general belief amongst the asylum seekers and indeed, whilst Nkem could not give her mental illness a name, she did give its cause: *"I was sick because I was thinking too much"*.

Physical and Psychological Scarring

It is hard to negate the impact that the migratory process had on the asylum seekers' mental health status. Six out of the eleven asylum seekers that I interviewed had been treated for a mental illness and although, in Daleel's case, his psychiatric problem was the result of a traffic accident, this accident had also occurred as a consequence of his flight.

For both Nkem and Ndidi, it was during their time at the closed detention that they suffered from some form of a psychotic episode for which they were admitted to the psychiatric hospital for treatment. The detention centre was also the place where Daleel's illness was re-ignited and whilst Akram had never been an inpatient in the psychiatric hospital, the first signs of his mental illness emerged when he was in detention. These asylum seekers had finally reached Europe, only to find themselves in yet another form of

imprisonment as opposed to the safe haven that they were seeking and this played havoc on their minds:

I got here in 2011 and I am in detention and I don't have family ... I don't even have any family to call ... and still they kept me in detention. I spent 8 months there ... I was physically well but I have nothing to do so I think ... I think too much and they took me to (name of the psychiatric hospital) (Baba)

Unlike the other 5 asylum seekers mentioned above, Patrick was living in the community when he was taken to the psychiatric hospital. He said that the police took him there because they thought he was crazy after having seen the environment that he was living in:

After I came back ... erm it was difficult when I came from Denmark. I don't have no place to go and I rented a place but its uncompleted and not good environment. So police came there and I think they thought I am crazy, or something like that, for living like that in that place. I don't know what they thought, that's why they went to take me to (name of the psychiatric hospital) (Patrick)

A rejected status also appeared to be another trigger for mental ill health, as Baba said: "They are rejecting me and they are making me crazy ...". One of the doctors whom I interviewed, recounted this experience:

I was on duty and this woman was brought in because when they told her she was not going to get refugee status, or any other form of protection, she swallowed Dove ... you know Dove ... the soap... a whole container of it! They do these things ... although I don't know if she was really suicidal because of a reactive depression, or because she was so desperate to stay and this was a way to force the authorities to rethink their decision. Whatever, we couldn't take the risk and she was admitted to (name of the psychiatric hospital) (Anna)

Maryan, one of the asylum seekers whom I had interviewed, was in the process of appealing a rejected status at the time of the interview. At that stage, Maryan had never

been diagnosed with a mental illness but her past history of rape and subsequent pregnancy, hormonal instability from having given birth 6 weeks previously, not having the benefit of any professional psychological support and her only family leaving for resettlement in the USA made her a likely candidate. As she said, in a flat tone and with tears rolling down her face: “ *I have a problem with my status reject ... my sister is leaving soon to USA. I have no-one else and I am worried a lot ... I am worried all the time ...*” (Maryan).

The migratory process does not only impact on asylum seekers’ mental health status but also on their physical status as a result of the dangers they encountered in their home country and throughout the journey. A number of the healthcare professionals that I interviewed referred to the scarring that they occasionally witnessed on their patients’ bodies. A doctor spoke about his own reaction when caring for an asylum seeker with a badly scarred body:

Sometimes, you know, you experience someone whose body makes you think of all that he has been through. You say, this person who is in front of me, hands down ... there is no need for discussion about giving him the refugee status and all this stuff ... just by seeing his shredded body ... (Tony)

Notwithstanding this, body scarring did not seem to bring out the same sentiment in all of the healthcare professionals, although generally, there did appear to be a morbid interest in these scars especially in how they had originated. An example of this occurred during one of my observations whilst in the treatment room. There was an asylum seeker from Somalia who had a work-related leg injury that needed dressing and he was therefore asked to get up on the couch. This patient had an old scar in the same area and the nurse who was treating him said in Maltese that this was definitely an old bullet wound. The four HCPs who were in the treatment room at that time all went to have a look and whilst the patient was still there, they had an animated discussion in Maltese speculating on how this wound had occurred and on the horrors that these asylum seekers must face when in their own country. Indeed, during both the interviews and informal conversations with the HCPs, the

majority appeared to believe that the traumas that the asylum seekers have experienced in the past still have an impact on their lives today, as this nurse says:

We do not know how they used to live, or where they came from ... these people left their country and came here so its obvious that they were suffering ... I think that their trauma of where they were keeps on affecting them. This is the same as when we pass through something ourselves and it keeps on affecting us but perhaps we are capable of distracting our thoughts because we have work but perhaps ... they don't work ... they are just there, circling the room ... (Joseph)

Through the Eyes of the Healthcare Professionals

The way that the majority of the healthcare professionals viewed the asylum seekers' migratory process was generally one of pity: "yes, *this poor thing ... who knows how much they have suffered? ... who knows what a lot of them have passed through?*" (Nurse, IC) and furthermore, a belief that people do not give enough consideration to their past suffering:

I think that we don't empathize enough with these people ... I think that we don't understand the suffering that they have passed through. You might ask me 'don't the Maltese suffer?' But I think ... you leave your country, you are on your own, you try to find work and often people also take advantage of you ... they get traumatic stress disorder ... we don't understand (Mark)

In fact another of the nurses felt that getting to know the asylum seekers' backgrounds would be beneficial: "*personally I wouldn't mind knowing more about ... erm ... especially where these people came from and why they left ... like what happened to them and also the differences and similarities of these people ... I think that it would help me ... yes, I think so*" (Miriam). Despite this interest to know more about them and their backgrounds, this nurse did not feel comfortable with asking asylum seekers any personal questions and this topic will be further addressed in Chapter Five which presents the findings in relation to communication issues.

Whilst the healthcare professionals acknowledged the migrants' tormented past, the majority of them demonstrated ambivalent sentiments and further spoke about how asylum seekers place an extra burden on resources that are already strained. The two nurses who were both so understanding in the above citations, also had this to say:

I see that those who came here, you're not going to send them away. You should try to welcome them and give them what they need. Then obviously in agreement with other governments perhaps ... because we are a small nation, we cannot keep a certain amount ... perhaps through agreement with other governments they can see where they can be transferred and give them the help they need. But once they are here, you need to give them care ... that's what I believe. You can't let them ... because they are human beings like the others (Joseph)

I do not agree with asylum seekers, I mean ... at the end of the day, I see them as an extra weight on us. This doesn't mean that I will maltreat them ... definitely not ... you treat them as a human being. The thing is we see that as a Health Centre we are very busy ... we are already very busy with the Maltese and now, we are more overloaded with these people as well ... and you need to take more time with them ... so you will be even busier ... (Mark)

As can be seen from the above quotes, these nurses both reported that despite their misgivings about asylum seekers and the migration situation, they would still provide the same quality of care to this cohort of patients. Although the fact that they felt a need to state that migrants are human beings, or should be treated as human beings, once again brings out a sense of 'Otherness'. Additionally, some of the asylum seekers themselves appeared to have picked up on the negative sentiments felt by the HCPs and when referring to healthcare providers' attitudes towards her, Nkem simply and possibly correctly said *"they don't like me because we are an immigrant you know ..."*

One of the doctors also voiced his reservations about the number of migrants in relation to the size of Malta, although he further emphasized that these reservations were totally unrelated to skin colour:

I ... I really don't care because they are black, or white ... there are asylum seekers who are white after all. For me, the only worry is crunching numbers ... in the way that how many can fit on this rock? That's it! Its not because we've filled up with black people, or we've filled up with white ... it's the numbers ... that is what worries me a little bit, although if you have a quick look at the statistics its not ... But I mean our country, it has limited resources ... (Tony)

Another of the nurses appeared to share similar personal sentiments as regards skin colour not being an issue when she said: “ ... *because the black ... because the white ... because the green ... isn't where we were born the only difference? Doesn't every nationality have the bad and the good?*” Despite this, as evidenced above, this nurse did add that generally the Maltese do have an antipathy towards people who are black. She further said that this is especially so amongst the older generation and recounted how in the past, the colour black had bad connotations:

I think that ... perhaps ... perhaps ... there is a difference with the way that the younger generation treats and views these people. In our times ... I remember my mother used to tell me ... I used to run errands for her and there was this dark field. That is there was a part of the way that I needed to cross that was dark ... and she used to tell me “hurry because the babaw⁷ will come to get you” ... but somehow this babaw was always portrayed as black! Even in my mind, a black person. So perhaps because we ... don't laugh with what I am about to tell you but could it be ... we paint the devil black ... so could it be that unconsciously, at the back of our mind, we associate black with badness? (Carmen)

One of the doctors whom I interviewed formed part of the younger generation but in spite of this and contrary to the nurse's argument above, she spoke about her fear of black men which she ascribed to her extensive exposure to negative media accounts: “*My fear is probably because I read so much about gang rapes and these type of things on the*

⁷ Babaw is a Maltese word for a fictitious creature that is referred to as a means of instilling fear in children to stop them from being naughty (Aquilina, 1987).

magazines. You will now probably ask me if them being black is the only reason that I am afraid of them.” (Anna). She then went on to explain how if she had to meet a group of Maltese men from a very rough part of the capital city and who are generally known for their violent tempers and criminal activities, she would be just as scared:

Now if they were from those of ... I don't know if you ever went into these slums in Valletta and those men who live there. If eight men were from these slums I would probably be more scared ... or at least as scared as I would be if they were eight black men (Anna)

The above statement clearly shows that for this doctor, the colour of someone's skin is a sole factor that sparks off images of savagery and brutality. She said that in addition to media exposure, she felt that this fear was also a consequence of the way in which, black men view women as lesser beings and as such felt that they could do whatever they wanted with them:

When I see the disrespect that they have towards women ... and I know that certain people, for them, in their culture, you rape a woman, its nothing! ... “Isn't that just a woman? Isn't that what she is there for?” ... so that's why I am a bit scared ... it can happen ... it can happen ... (Anna)

Furthermore, when discussing attitudes towards asylum seekers a nurse said: *“racist attitudes are not only restricted to skin colour but even just a different religion, or just a different way of living life”* (Maria). If this statement is truly representative of how a segment of the Maltese population feels, how does this augur for black people who, by the sole virtue of their skin colour are bound together under one culture, one religion and other traits, all of which, the Maltese population view to be very different and inferior to themselves. In fact, during my observation, one of the nurses said: *“let me tell you, those who are ... dark-skinned, its like for me I place them all in one basket.”* (Nurse, IC) and despite a number of healthcare professionals negating this commonality: *“everyone is different and in every culture you will have some who are like this and some who are like*

that” (Joseph), another nurse did refer to a general trend amongst healthcare professionals to batch all black people together, under the unfavourable label of asylum seekers:

I feel that we have a bit of stigma towards them ... like ... all black people in our minds are asylum seekers and it might be my perception but it is as though we think of them as second class citizens and this bothers me ... Let me say that I cannot say that I have ever seen them being maltreated but I still get a certain vibe that there is a bit of stigma where they are concerned ... one, they are all placed in one and the same basket and yes I feel ... I might be wrong ... but I do feel that yes, we tend to treat them like second class citizens (Carmen)

So despite Joseph and Mark’s protestations of treating asylum seekers well and as ‘human beings’, there is also conflicting data that shows that negative sentiments might at times be discernible. This will be discussed further in the upcoming chapters.

Summary

The findings presented in this chapter have shown that irrespective of the reasons underlying their departure from their countries the asylum seekers’ journeys in search of refuge are fraught with danger and suffering. On arrival in Malta, they are locked up in detention like criminals, which compounds past suffering. Added to this, having nothing to do except think for days and months on end, results in psychiatric problems for a substantial number of these asylum seekers. The asylum seekers’ marginalisation and segregation continues unabated, even on release from detention into the community, as evidenced by their lack of social relationships with individuals other than asylum seekers like themselves. This, in addition to a migration status that is temporary, or has been rejected and their inability to find a secure job with decent prospects in line with their skills, results in a sense of impermanence. The situation is further aggravated by the differentiation that is made between “Us” and “Them”, as revealed by a number of the HCPs’ testimonies, made potentially more harmful by the HCPs unwavering conviction that, irrespective of their beliefs in relation to asylum and asylum seekers, the healthcare that they provide them with is no different to that of the rest of their patient population.

The relevance of the above to healthcare encounters between asylum seekers and HCPs will become increasingly apparent in the upcoming two chapters that present findings directly related to the interactions within these encounters, as the participants attempt to achieve a resolution to the presenting healthcare issue. The next chapter will discuss the participants' experiences of communication within these encounters.

Chapter 5: Seeking Mutual Understanding - Communicating within the Healthcare Encounter

Introduction

The nature of the patient-provider relationship has been cited as one of the strongest influences on patient satisfaction (Van de Ven, 2014) and has also been shown to have an influence on positive healthcare outcomes (Moll et al, 2015). The ability to communicate effectively both verbally and nonverbally is not only central to the development of therapeutic healthcare relationships but is essential throughout all the stages of the healthcare encounter (Fong Ha & Longnecker, 2010; Kourkouta & Papathansiou, 2014). Communication difficulties due to linguistic discordance and other factors were clearly evident in both the participants' narratives and the observational sessions, as each one of the participants struggled to achieve a shared understanding during their clinical encounters. This chapter presents these findings through the second theme entitled "Seeking mutual understanding: communicating within the healthcare encounter" and through the four sub-themes namely 'linguistic discordance'; 'it's not just the language'; 'mistrust and misunderstanding' and 'power differentials and control'.

As can be seen from the pen portraits in Chapter Three, after excluding the cultural mediators, four out of the eleven asylum seekers who had been interviewed could not speak, or understand, any other language than their own. These four asylum seekers were Somalis and the observational data shows a similar pattern with a substantial number of Somalis, especially women, who could only speak and understand Somali. The linguistic proficiency of the rest of the asylum seekers whom I met during the observational data collection varied, with a small number of these having learnt Maltese but generally, their second language if any, appeared to be dependent on which European power their countries had formerly been colonised by. Similarly, having been a British Colony till 1964, both English and Maltese are official languages in Malta and at the time of the data collection, all of the HCPs whom I observed were proficient in the English language, including any of those who were non-Maltese. Additionally, a substantial number of Maltese understand and speak Italian to a varying degree and whilst the majority are not

proficient in Arabic, a very basic understanding could at times be achieved because of similarities between Arabic and Maltese spoken words.

The findings below are replete with the challenges that the participants faced because of linguistic discordance particularly within the context of a primary healthcare setting. However, effective communication is not solely dependent on linguistic concordance and both the participants' narratives and the observational data shows the impact that the context, such as the social and cultural environment, has on achieving or not achieving the shared understanding that is being sought.

Linguistic Discordance

"The most challenging aspect of care" (Nurse, IC), is how the majority of the healthcare professionals described language discordance in relation to healthcare encounters. As a nurse said:

The language barrier is a major challenge ... a big challenge because you try to speak to them in English ... you try Maltese ... perhaps a bit of Italian but we soon realized that a lot of them don't speak any other language but their own and if there is no cultural mediator its really difficult. (Maria)

The following doctor's comment clearly shows the challenges alluded to above:

There are times that we would be speaking in three languages at once to try to understand each other ... at one moment he is speaking to me in English, another moment in Maltese, or another moment in Arabic ... otherwise you try to see how you can understand through pictures, or sometimes you solely carry out a physical examination ... (Anna)

The nurse in the following citation was the only healthcare professional who felt that he had never had an experience where language was an insurmountable barrier:

Me personally I never experienced any language barriers ... whenever I tried to communicate with them I always managed, they always understood me ... if I asked them not to wet their wound, they wouldn't ... sometimes female asylum seekers come alone with their babies either for the doctor, or the nebulizer. In these cases there might be a slight problem with language but we never needed to get an interpreter, or really had no idea what to do (Mark)

Whilst this confident assurance is slightly worrying in view of a lack of any consideration of the possibility of unmet needs, a feasible explanation for this exception was that this nurse worked in a Health Centre which did not cater for such a large number of asylum seekers and he thus had less exposure. His sentiments contrasted considerably with one of the doctors whom I interviewed and who cited both asylum seekers' unmet healthcare needs, as well as legal consequences for himself, as potential undesirable outcomes of linguistic discordance:

For me when I see an asylum seeker without a translator and with a translator it's a though you are saying ... you know ... heaven and hell ... because sometimes you find that your back is against the wall and that you don't have a translator and you can get through the communication barrier in one way, or another ... signs... a bit of Arabic ... a bit of this and a bit of that ... but sometimes you can't and these ... the worst is that they have unmet needs, or I'm missing something. Huh! And you know, something happens to him and then its an inquest and all of that ... anyway when you see a translator coming in, its 100% less stress (Tony)

The majority of the healthcare professionals cited unmet needs as the undesirable outcome of linguistic discordance and this concern was also voiced by an asylum seeker during observation who said: *"How can the doctors and nurses know my problems and help me, when many times that I come here there is no interpreter ... how can I make them understand?"* (AS, IC). Moreover, possibly because of the nature of their diagnostic role and as evidenced in the above quote, the doctors further showed a concern of missing out on something medically important, as well as the potential repercussions of this lapse. As

another of the doctors said: *“you need a translator ... you can’t take the risk because if you document that you have examined him and you miss out ... lets say a woman with an ectopic pregnancy ... you really have gone and done it then!”* (Doctor, IC)

During observation of the clinical encounters, the validity of these concerns was clearly evident as there were numerous situations where both the patient and the doctor struggled to make themselves understood, often with minimal success and at a potential risk to the patient’s safety. A frequently occurring example would be when the doctor would have succeeded in diagnosing an illness such as tonsillitis, or a respiratory tract infection through a physical examination and would need to prescribe antibiotics. In these situations it was nearly always impossible for the doctor to get a coherent answer to the question of whether the patient was allergic to penicillin, irrespective of the many different ways and times that this question was posed.

Because of these potential risks and in the absence of a cultural mediator, the doctors would often ask an asylum seeker to go to find someone who could act as a translator:

This happened to a colleague of mine ... she is a doctor. Anyway, the migrant he couldn’t understand ... my friend couldn’t say a word ... in fact she wasn’t saying a word. He couldn’t make himself understood and she told me that they spent 5 minutes staring at each other ... she just couldn’t understand and he couldn’t explain and she opened the door and said “I’m sorry, get a translator and come again” (Doctor, IC)

The asylum seeker being given the responsibility of finding their own interpreter was also evident during my observation, with frequent occurrences of patients coming out from the doctor’s clinic into the waiting room and looking around and approaching anyone they thought would be able to translate for them. Whilst the majority would be successful and come back with someone to act as an interpreter, there were also instances when they never came back at all. Another practice I observed in the waiting rooms were asylum seekers striking up a conversation with someone unknown to them. If these new acquaintances were discovered to speak English, the asylum seekers would ask if they would accompany

them on their medical visit to act as translators. As will be seen in the discussion, the practice of using strangers to help with interpretation in healthcare encounters raises a number of concerns, with confidentiality issues being a major one.

Going to the Health Centre with a relative, or a friend who could translate for them during the clinical encounter, also appeared to be common practice amongst the asylum seekers. Akram who speaks both English and Maltese said:

“It’s obvious that those who do not know English, or Maltese will not know how to describe their problem well. Twice they have asked me to go with them. I had gone with them to speak to the doctor” (Akram)

One asylum seeker also said that if he felt that the HCP was saying something important, he would phone a friend and try to manage over the telephone. Another strategy that the asylum seekers would use would be to come to the clinic with the symptoms written on a paper in English and the doctor or nurse would write any medication or advice on this paper again. Obviously, in these instances, the patient would be unable to answer any further questions about symptoms, or understand the treatment options or prognosis, resulting in a very unsatisfactory encounter.

Possibly as a result of the utilisation of the above-mentioned strategies, the non-English and non-Maltese speaking asylum seekers whom I interviewed either did not seem to view language discordance as an insurmountable barrier: *“Its not always the same. Sometimes I would get an interpreter when I am at the clinic and sometimes I take my own interpreter with me ... I never had a problem, I always find an interpreter”* (Sabo), or were resigned to these types of arrangements: *“I went to (name of Health Centre) Health Centre to make an appointment for the injections for my baby and there was a Somali man there waiting to see the doctor and he helped me. It is not always easy but most times I manage”* (Maryan)

There are other plausible explanations of why the asylum seekers whom I had interviewed did not view this discordance to be such a problem. One such explanation could be that two of these asylum seekers were getting support from a non-governmental organization

(NGO), which whenever possible, would provide linguistic and medical support on their visits to the doctor. Another two lived within communities that also provided them with linguistic support which might therefore have affected their responses. Additionally, the significance of linguistic discordance could have paled in the presence of other more pressing concerns, as in the case of Maryan, who was appealing her rejected status whilst having to contend with raising a newborn baby in an inadequate environment, and with her sister soon to be resettled in the USA. Nevertheless, there were a few asylum seekers that I met during observation who bemoaned the lack of available interpretation services, such as one woman who said: *“the lack of cultural mediators is one of the biggest problems. What I do is ask them to write down everything and then when I go home, I get a friend to read it and explain it to me”* (AS, IC).

Sabo, who was cited above, was accepting of the lack of interpreters and also appeared to have adopted local political and public discourse, when she argued that it would be logistically impossible to provide the amount of interpreters needed:

There are many health services ... there are many Health Centres and the hospital is very big ... it is a huge hospital. So you need a lot of interpreters at one time to be in all these different Health Centres ... and in the hospital one interpreter is not enough, they need many people at one time ... it cannot be... when I go for vaccination for my child, there is no interpreter but if I need, lets say my child is sick with flu, or something I get my own ... someone who speaks the language.
(Sabo)

Similar to Caadil as mentioned in the previous chapter, Sabo and her family were waiting for a date for their resettlement to the USA and this desired outcome could have affected her perspective of the situation in an ultra-positive manner.

Utilising any of the above-mentioned strategies to overcome linguistic discordance did not automatically mean an end to communication problems. During observation, on many an occasion, the doctors would turn to me and indicate in Maltese that they did not have confidence in the competence of the translation: *“I think that even the supposed translator*

is messing up! (Doctor, IC). In this specific situation the patient was complaining of some type of flank pain but the friend he had brought to interpret for him could not understand many of the doctors' questions in relation to the nature of the pain and other important symptoms that would enable a diagnosis. As a result of a lack of necessary medical information, further investigations had to be taken.

In another instance, a nurse who understands some Arabic, described a situation when she realized that the translator, who was a friend of the patient, was not translating correctly: *"I asked this person to translate and he wasn't telling him what I was telling him to say and I told him "that's not what I asked" and they both just left and didn't come back"* (Miriam). What I noticed during observation was that these unofficial translators would often answer the healthcare professionals' themselves, without bothering to translate the question for the patient. In fact, a doctor claimed that he often experienced situations where the translator actually chose what information would be given to the patient:

Sometimes when there is a translator, I don't know if he is the patient's husband, or her friend ... Somalis ... Somalis, or whatever ... sent from the woman's settlement and he decides that she doesn't need blood tests and in these instances he doesn't even bother to translate and tell her what I am suggesting and just says "no"
(Tony)

Another doctor also felt that the situation was worse when the patient knew the person who was translating *"I see that the interpreter bothers them most if it is their friend who is translating ... because imagine ... this woman is married and then her husband's friend is doing the translation, so she won't tell him everything"* (Anna). Iman, one of the interpreters, corroborated this and said that there were instances of patients being untruthful about their symptoms because of embarrassment and a fear that the person who was doing the translating would gossip about them afterwards. He claimed that this was not the case with regard to professional interpreters who are specifically employed for the job:

When they are not being truthful, or they change the symptoms, it is probably because they are shy of the doctor and the translator and think that he will tell others about their condition ... For me it's different ... they know that I am professional. I have a tag and they know that I will not go and speak about them when I leave work. So they don't seem to have any problems with being truthful in front of me. (Iman)

As described in Chapter Three, although the situation with regard to cultural mediators had certainly improved throughout my data collection, there were still significant periods when the service was unavailable. The dilemmas that could arise if an emergency occurred during the interpreter's absence are virtually palpable in this doctor's agitated account:

When there is an emergency with an immigrant, then I start getting a little bit jittery because during an emergency you can barely take a history in Maltese, let alone in a different language ... no, no, no ... one came who was really vomiting, you realize that he is dehydrated ... you need to explain to him "I want to set up a drip" ... this patient was from West Africa, they have a strong, good reserve do you understand? So I started worrying because I was seeing him really weak for someone from West Africa and you realize that this means trouble ... serious trouble ... we wanted to explain to him but he didn't really speak English, he spoke French ... I don't know French damn it! At that time there was no one who knew French in that shift ... Oh God! So I wanted to insert a venflon so he would ... I wanted to explain what he has ... he was vomiting all over the place ... Nooooo (said with a shiver) ... a nightmare! I needed to refer him to hospital but I needed to stabilize him first and there is also another issue ... I did it in his best interest but sometimes I also have an issue ... is there appropriate consent? What I mean is, this particular case, certainly he's not consenting to anything! I just got on with it, sticking in needles, setting up drips and so on ... without consent! ... I erred on the side of caution, I tried to do good but it got to the stage where I told him "okay stop ... me doctor, me help you" ... end of story. At that time you won't be thinking but after you feel like an arsehole ... this issue about consent at times gets to me ... we practice the

paternalistic type of medicine with asylum seekers because of this communication barrier and this is contrary to what I believe in... (Tony)

As previously mentioned, cultural mediators were only available in one of the Health Centres which catered for the largest number of asylum seekers because of its geographical location. Notwithstanding this, the other Health Centres would still be required to provide healthcare services to asylum seekers and in so doing, would invariably encounter linguistic problems:

In fact, we do often get asylum seekers, everyday day of the week ... he might know a little bit of English ... or he might know a little bit of Maltese and you try ... erm sometimes even with sign language we try to understand each other. So somehow we get there but still ... I wouldn't have any idea of whether he understood all that we wanted to tell him, do you understand? How much he actually understood of what we told him ... (Carmen)

Sign language was just one of the strategies that I observed the HCPs adopt, in an attempt to get the asylum seekers to understand what was being asked, or being said: “... we use sign language ... we show them and for example, we write the appointment on the card and you try to underline and point the date out ... huh! ... its difficult ... yes, it's difficult” (Joseph)

Once you can't succeed through language you try through signals ...you try to get them to understand ... you explain to them, perhaps you draw, you write on a piece of paper... then sometimes you see them staring blankly at you because they wouldn't have understood, so you try to explain to them again in an easier way for them to truly understand (Miriam)

Despite the fact that HCPs in Malta are proficient in English, Ndidi and Nkem, two of the asylum seekers whom I interviewed, reported that nurses, apart from speaking amongst themselves in Maltese, would also speak to all their patients in Maltese, even though it was clear that these particular patients could understand English and not Maltese: “The nurses

always speak Maltese to each other and sometimes they refuse to speak to me in English and obviously I cannot understand what they are saying” (Ndidi); “Sometimes some of them speak Maltese... if you don’t understand like me, you think they talk rubbish with you” (Nkem)

As previously mentioned, Malta was a British colony until 1964 and English is utilised for educational courses at tertiary level. It is therefore safe to assume that all healthcare professionals are proficient in the English language, making it hard to understand why they would choose to speak Maltese with English speaking patients. As I have already reported in the previous chapter, I did observe the practice of healthcare professionals speaking and passing comments in Maltese in the presence of non-Maltese speaking patients but I never came across any healthcare professionals speaking Maltese to patients who could only understand English.

The majority of the healthcare professionals I observed appeared to try their utmost to achieve some understanding and would further try to ascertain whether the asylum seeker had understood. One nurse claimed he could decipher such understanding by the reaction of the patient. Similarly, two other nurses also believed that they could tell when an asylum seeker had, or had not understood, adding that it would not simply be because the migrant claimed this. Indeed, they made the point that patients sometimes indicate understanding when this might not actually be the case:

They say yes ... and then you can see it from their eyes that show that they haven’t understood anything. You might try to repeat but ...” (Carmen) “I think the first and foremost challenge is language...very often they say yes and then you think ... no way, they haven’t understood a word!” (Maria).

Another nurse described what could happen in the instances that the asylum seeker just could not understand what the HCP was trying to convey in a busy clinic situation:

I think we tend to deal with numbers ... it’s as though we don’t deal with people. So if you see that there are loads of people knocking behind the door ... erm ...

and perhaps we are trying to make this patient understand and we are not being at all successful. After a while we tend to give up and say “okay, this is it, okay?” As long as we get rid of him and can get on with it ... I think that the language has a great impact... although it’s not just the language ... (Carmen)

It’s not just the language

The healthcare professionals whom I interviewed believed that language discordance was not the only factor that impacted on communication and ultimately, on the success or otherwise of the healthcare encounters. In fact they cited “culture” and health literacy as co-dependent influential factors. The majority of the HCPs discussed “culture” through an essentialising discourse that depicted a simplistic image of all asylum seekers as one homogenous group with a shared culture: “*Let me tell you ... those who are ... dark skinned ... it’s as though for me, I gather and place them all in one basket*” (Nurse, IC). Additionally, the majority of HCPs’ discourses accentuated the “Us” and “Them” dichotomies: “*I believe that we should keep our distance ... because our culture and theirs is different ...*” (Mark) and generally contended that “*their culture*” is a way of living often based on religious mores and one that renders asylum seekers incapable of understanding ‘superior’ systems to be found in ‘Westernised’ parts of the world.

... It’s also the culture ... as I am saying, a different language, a different culture. You perhaps are trying to explain something to them that they are not understanding 100% in the way that you are explaining. So already they are not understanding and then, they are not understanding because of the way that I am presenting the information! So I think that if you have someone who can ... someone from their culture, who could understand their culture ... who can explain what we are saying in a much better way (Carmen)

I think that those who can speak English will still have certain problems ... not all. I think that those who have some knowledge before they come here can communicate and that ... I think it is better ... But those who are just starting and don’t know anything ... its not easy to communicate you know (Miriam)

With new cases, getting a medical history is often problematic, you don't really get a good medical history out of them ... It's like they don't know. For example, you ask them "have you been vaccinated against tetanus?" they say, "I don't know", or "what is that?" It's not because of language, I think it is because of their medical background ... I imagine that in their country they do not have the same level of health that we have (Mark)

Patrick, an asylum seeker from Sierra Leone, appeared to agree that culture and health literacy played a major role in effective communication when he claimed that the colonisation of Sierra Leone by the British was ironically beneficial in that it helped him to understand the system in Malta and to communicate adequately with other English-speaking people:

Africans from East Africa, they have a lot of difficulties more than those from West Africa because we were colonized earlier, before the white people discovered the East and so, they have more relationship with the Arabic world ... more than we Western part ... so we are more advanced ... educated more than they. So this makes it easier to understand the system, once we ourselves were colonized for a long time and the last colonizers were the British ... yes, its an advantage ... yes... its more easy to speak to people from English-speaking countries (Patrick)

Possibly as a result of a similar history of British colonisation, Patrick appeared to have adopted a Westernised ideology of superiority akin to that of the healthcare professionals in Malta. These unquestioned notions of 'Western superiority' resulted in HCPs' attributing generally negative and similar key attributes to the asylum seekers and which, as mentioned above, served to amplify the asylums seekers' supposed homogeneity. Despite these allusions to homogeneity, there was a degree of ambivalence in the way that HCPs' further differentiated between the asylum seekers, whom they then placed on a hierarchical scale according to what they perceived to be desirable, or less desirable characteristics. Those asylum seekers who HCPs' perceived as possessing an increasing amount of dissimilar characteristics to themselves, were placed on the lower rungs of the

hierarchical scale, providing another illustration of the consequences of subconscious and therefore unexamined ‘Western’ and ‘non-Western’ binary constructions. Indeed, the following citation shows how characteristics such as speaking good English, a willingness to adapt to the host country’s culture and a show of appreciation for the care that they have been provided, are deemed to be desirable by HCPs:

You notice there are certain people who are adapting to our country and others don't ... yes, the Somalis are the worst, they just don't even try to adapt ... the Somalis are the worst for me ... the Somalis have typical faces and also ... its not only me who says this, other nurses also say this and its not only between East and West because character wise, the Eritreans are different and then people from Niger and Chad, or wherever they were from ...they are very nice and they speak good English ... even Nigeria they are nice, even they appreciate what you do for them ... probably there have been Somalis who appreciated and everything but still ... (Anna)

The gist of the argument posed in the above citation was similar to two different discussions amongst healthcare professionals that occurred during my observation. In both these discussions there appeared to be a general consensus amongst the HCPs on the way that they placed these patients in a hierarchy, with some national or cultural groups regarded as ‘better’ than others. In these stereotypical constructions the Somali population was mainly placed at the bottom of the hierarchy. It was commonly reported that “*The Somalis are the worst*” out of all the asylum seekers (Nurse, IC) and adjectives such as “*uneducated*”, “*rude*”, and “*demanding*” were used by the HCPs to describe them. This perception is corroborated by the following citation, where Jamaal, one of the Somali interpreters, describes how Somalis are automatically viewed in a negative way by HCPs, unless these Somalis demonstrate, or assume ‘Westernised’ characteristics and in so doing, are more similar to the HCPs:

There are a lot of misconceptions about Somalis amongst the Maltese but when they see that you are educated, wear Western clothes and can speak English, then they treat you differently. When I went to the emergency and was admitted to

hospital, at the beginning they were not very forthcoming with me but then, when they realized that I could speak English and Maltese well and could understand them and in a way acted like them ... their attitude changed. (Jamaal)

The majority of Somalis who arrive in Malta would have been of school age when the war in Somalia erupted and so, a substantial number of them would not have had the benefits of an adequate education, or experience of an effective healthcare system. My observations confirmed that the majority of Somalis could not speak English and even when a cultural mediator was available, some of them still had some difficulties with understanding further instructions, especially when these were associated with referrals for some investigations, or specialist clinics. However, I never observed any Somali patients who were rude or demanding. On the contrary, my experience was that often the Somali patients appeared introverted and submissive during the clinical encounters that I observed. It is somewhat paradoxical to note that for a substantial period of time a number of the healthcare professionals worked with a cultural mediator from Somalia, who as mentioned in a previous section, was described by the HCPs as “*educated*”, “*helpful*” and “*very nice*”. Yet, the good opinion held regarding the Somali mediator did not appear to temper the negative stereotypical views that the HCPs held about Somali people in general.

According to one of the nurses, HCPs’ attitudes and their communication approach towards asylum seekers are influenced by two factors, namely, their skin colour and the religion that they ascribe to, implying that being “non-white” and “non-Christian” negatively impacts HCPs’ behaviours: “*A mixture of both colour and religion ... in fact it’s not necessarily colour, even solely a different religion*” (Maria). This remark is a reflection of the importance that the Maltese population generally assigns to religion, with a substantial number of Maltese people assuming a Catholic identity and with Catholicism in Malta not only being predominant but also recognized as the official religion by the Maltese constitution. Since 2002 and up to just after the period of data collection, the majority of the asylum seekers who arrived in Malta were Somalis, with most of these being Muslim and which, gave rise to a populist discourse of Islam as a “threat” against Maltese Catholic and cultural identity. This perspective has been increasing in intensity along the years and Islamophobia is a tangible reality in present day Malta, with Islam

additionally considered as a ‘threat’ against national security. The testimonies of some of the HCPs in this study showed an affinity with the public’s Eurocentric view of Islam and Muslims as inferior. Some of these testimonies further failed to differentiate between cultural and religious norms and pointed to Islam as a source of gender inequality and the cause of what the HCPs’ viewed as primitive practices, such as female circumcision and polygamy:

Their religion keeps the woman down and it is the men who have all the say. This is why women are forced to cover themselves ... there are those who even have netting over their eyes ... no, this is definitely not for me! What about genital mutilation? We have had a few come here with raging infections because of this ... but of course only the Muslim women have to suffer not the men ... it’s like they are still living in medieval times (Female Nurse, IC)

I think that their religion makes a big difference on how much they are taught ... or perhaps, more of what they are taught. I think that they try to keep them a bit ignorant of certain things ... especially the women. Otherwise, if the women were educated, they wouldn’t let the men have more than one wife would they? Even the men you know, they do not understand a lot of things that we tell them but perhaps this is not only because of their religion ... after all, they do come from the jungle don’t they? (Male Doctor, IC)

As can be seen from the above latter citation, being Muslim is one, but not the only reason, for some of the HCPs’ perceptions of asylum seekers being educationally inept and of them being unable to understand medical instructions. Indeed, the above comment about how the asylum seekers’ environment in their country of origin was a jungle, clearly illustrates how the stereotypical images of Africans that some of the HCPs have are remnants of colonialism and a colonial imagination. Irrespective of the true cause of asylum seekers’ lack of health literacy as perceived by the HCPs, the majority of the doctors and nurses expressed their frustration at the extra time that these patients consume:

They obviously take up more of our time for you to explain to them ... not only because of the language but lets say ... some-one has to go for an X.ray, so you need to explain about the X.ray ... what it is, why and whatever ... you have to explain where he has to go ... you have to explain what he has to do to get the results and often they still don't understand ... and all this time, you know that more and more people are waiting for you outside! Even just for a dressing ... till you explain to them, they would take up more time (Joseph)

There are also structural constraints on services which have exacerbated the challenges associated with meeting the communication needs of patients. During the data collection period, several doctors mentioned an undocumented drive by the administration to standardise the length of doctor-patient consultations to an average of ten minutes, irrespective of the nature of the medical encounter. Whilst these doctors had previously already being pressurised to see patients as fast as they could, this would be the first time that a time limit, albeit flexible, was to be imposed on healthcare encounters and served to cause further stress to a situation that was already viewed as a taxing experience:

To top it all, there is now this drive from the administration recently to (sheering sound) for the doctors' visits by UK standards ... an unwritten policy ... one consultation for 10 minutes, something like that, or as an average, lets say that. There has been some resistance ... don't they know what we are facing? (Tony)

In addition to time pressures, another reason for the negativity towards these patients relates to feelings of incompetence and discomfort that some of the healthcare professionals appeared to experience when faced with someone whom they viewed as being of a very different culture with totally different experiences to their own. A number of these HCPs' expressed a concern about "causing offence" by asking questions of patients "*what keeps me back from asking questions is that I might offend him ... or bug him*" (Miriam). Others were concerned that questioning patients could open up emotional wounds that they would then be unable to deal with appropriately:

I find it hard to have a whole conversation with an asylum seeker. A Maltese person asks you “where are you from?” and he starts telling you his problems ... that sort of thing. With an asylum seeker I don’t feel so comfortable to start a discussion about him because he ... you are expecting him to tell you “my family died like this and he died like that and I’ve seen this” ... as though ... I wouldn’t want to open any wounds (Mark)

HCPs further spoke about their fear of “causing offence” because of a perceived lack of knowledge in relation to specific cultural and religious issues and this was felt so strongly by some of the healthcare professionals that they reported that they would not offer their patients all possible medical options. For example, this doctor described a situation where her lack of knowledge resulted in her “interpreting” the needs of the patient incorrectly. Indeed, rather than explain the problem and ask the patient about her needs and preferences, the doctor made a decision about medical treatment based on the assumed characteristics of the patient and which she derived from her ‘knowledge’ of the patient’s religion:

This happened with a Maltese woman who was married to a Libyan and I didn’t offer the contraceptive pill because ... she came with menorrhagia and she had a haemoglobin drop ... I didn’t offer her the contraceptive pill because I didn’t know how their religion views this ... and then I went and read on Wikipedia and it tells you that a woman can have the pill ... (Anna)

The lack of knowledge that the above-cited doctor demonstrated in relation to specific religious mores was also evident amongst other healthcare professionals and further extended to include an ignorance of cultural norms. This doctor’s description of his first medical encounter with an asylum seeker shows how the doctor’s lack of knowledge about what was behaviourally unacceptable in the patient’s culture evoked a negative response, with the encounter being brought to an abrupt and unsatisfactory end:

I remember the first one ... the first Somali woman I saw ... So I got up and shook her hand and this woman got up and ran out of the room shouting because I had

touched her. I wasn't her father, or her husband or the leader of the tribe that are here ... so you know, I invaded her privacy. Now I didn't touch her at all, I just shook her hand (Male Doctor, IC)

This testimonial does not only show the consequences that could result from the HCP's lack of knowledge but further demonstrates a lack of understanding and sensitivity on the doctor's part when reflecting on the encounter. As mentioned above, a substantial number of the HCPs appear to be aware of their own lack of knowledge in relation to cultural and religious norms and expectations and a few of their citations have already been provided and show how these HCPs, generally nurses, resort to reticent behaviour when communicating with asylum seekers for fear of causing offence. Additionally, the majority of the HCPs appeared to experience discomfort because of the resultant uncertainty and they attempt to compensate for this by indiscriminately bestowing stereotypical identities upon the asylum seekers. An example of this can be seen in the HCPs' narratives around asylum seekers and gender issues, showing how the HCPs' formulate an ethnicised gender identity that they attribute to all the female asylum seekers: *"I understand these women ... they always need a female presence ... they cannot have a man treating them"* (Maria).

The following citation was provided by one of the male nurses and it describes how he invariably informs all female asylum seekers that if they prefer to be attended to by a female nurse, they could wait until one is available. He further reported that to date, no asylum seeker has taken him up on this offer:

I have never met any cases where the patient refused me taking care of her because I am a male ... When I see a female patient I tell her ... I ask her permission because I am a man and then if she tells me that she prefers a female nurse I tell her " then wait a bit for a female " ... But till now I have never come across this (Joseph)

The following doctor, who is representative of a substantial number of other doctors working in the general practitioner clinics, reported employing similar strategies with their asylum seeker patients:

If it isn't an emergency and it is relating to a sensitive area, like from the belly button down, I say "there is a female working at the moment, would you like to speak to her?" or "listen, after 5pm there will be a female, you can wait, or come back again and I will write you a note" ... Sometimes they say, "yes, I will go to the female" and sometimes they say "no it's okay" (Male Doctor, IC)

Whilst these last two citations illustrate how HCPs' constructed identities of female asylum seekers', albeit essentialist and typecast, result in a measure of sensitivity towards these patients, there is also the potential for assumptions such as these to work against the interest of the patients. Maria, a female nurse who was cited above, upholds such a firm conviction that all female asylum seekers require female HCPs attending to them, that whenever a female asylum seeker comes for a medical consultation which Maria deems to be intimate and there is no female doctor on duty, she automatically advises the patient to come back at the time that the female doctor would be on duty:

There was a case recently ... there were no female doctors. She had something wrong because she had a past history of FGM ... some infection because she was febrile. I went to the reception to check and see when the next female doctor was on duty and so I then told her to go home, take two panadol and stay in a cool environment and to come back at 5pm. When the female doctor arrived I told her about this woman but till I finished my shift, this woman had not yet come back. In fact I had forgotten about her ... I don't know if she ever did (Maria)

Despite Maria's conviction, the majority of the male HCPs asserted that generally, female asylum seekers did not demand to be seen by female HCPs. It is unclear whether the female asylum seekers were genuinely happy with this situation or willing to endure it for fear of appearing to be difficult, or demanding, or whether most women did in fact not regard it as a major problem. The acceptance of a male doctor by the majority of these women is possibly explained by the experience of Sabo, a Muslim woman, who said:

Our religion says that if you are sick and you cannot find a female doctor, you can go with a male doctor ... If I had a choice I should choose a female but for me, I thought that the doctor only was a male, so it's my duty (Sabo)

In Sabo's case, it does not appear that she was given a choice. As previously described, whilst the GP clinics and treatment rooms are staffed with both male and female HCPs, the specialist clinics in the Health Centres that function on a referral and appointment system, such as the gynaecological and obstetric clinic, would have solely one doctor, either male or female, providing their service in one clinic session, rendering it impossible to offer asylum seekers encounters that are gender concordant. Additionally, all of the cultural mediators who were employed at the Health Centre throughout the course of my data collection were males, although Iman, who was one of these cultural mediators, did not feel this to be a problem:

Very rarely they ask if there is a female but most of them do not seem to mind and they just say okay. They think that there is no other option for them and it is so much better that now they have someone to translate, unlike how it was before that they don't mind because I am a man (Iman)

This, however, was not a view always shared by the healthcare professionals. For example, some doctors felt that having a male interpreter was problematic because of modesty and privacy issues and discussed the potential for this to obstruct the asylum seeker from giving a truthful account of her symptoms: *"We only have male translators here, so a female patient will not tell me if she has ... let's say ... a breast lump ... or dysuria ... or something like that"* (Male Doctor, IC). Problems would also arise when a female patient needed a physical examination and a doctor described the time consuming measures that they would often need to go through to retain the patient's privacy and modesty, such as examining the patient whilst the interpreter stood and translated behind a screen, or curtain:

So this patient, a woman ... if I remember well she was from Somalia ... anyway, she was on her own and (name of cultural mediator) came in with her. She was complaining of abdominal pain and obviously I needed to examine her. Well we

were in GP 2 where there isn't even a curtain, so obviously I couldn't examine her there and we had to go into the treatment room. There weren't any free cubicles, so we had to wait until there was one and then ... all those clothes that they wear ... Anyway, after all this I could finally examine her, with the translator behind the curtain doing the translating. All this hassle for a simple abdominal examination... I don't blame them you know ... but still ... (Male Doctor, IC)

Whilst several of the HCPs recounted stories of the strategies that they would implement to provide what they perceived to be culturally competent care, a minority of HCPs reported that they had witnessed incidents that they interpreted as racist and which caused them distress. For example, a nurse spoke about how she felt when she observed procedures on asylum seekers being carried out in a different manner to usual, as well as a different communicative approach being utilised:

"They are carried out quicker than usual and even ... if he is hurting they tell him "Oh come on! Are you going to keep on shouting?" (said in a loud and aggressive manner) ... this is what I see sometimes unfortunately ... and I say come on, come on, that's a human being ..." (Maria)

The asylum seekers' testimonies in relation to the quality of healthcare provision that they experienced were varied. A good number of the migrants had only positive comments to make. This was particularly the case for the Somali participants, despite the fact that this population is generally poorly regarded by HCPs. As I will discuss further in Chapter seven, this could be related to low expectations and prior experiences in their home country. So much so that the migrants would make direct comparisons between the care they received in Malta and that available to them in their country of origin. As Caadil and Maryan commented:

When you are in Somalia, we have no government, we have nothing ... we have no material, we have no doctor ... nothing. Here it's better ... here ... When I was in Somalia I had to pay a lot of money for medicine (Caadil).

I have been treated like they treat the Maltese ... equal. If this number is before me I just wait and the next time they will see me ... and when they see me ... they make me better. In Somalia this would not happen for free, you would have to pay
(Maryan)

Furthermore, some of these asylum seekers like Maryan, were facing so many other pressing problems in their lives that as long as they could get free healthcare provision, other factors such as the health care providers' approach was possibly not so significant:

I have been here for three years, since 2010 and till now, I have never had any problems with the health services because I can go ... I can go for free if I am sick, or something like that ... the problem is not the health services, the real problem is I don't have anything ... I rejected ... the government has rejected me (Akram)

Most of the other asylum seekers did not find fault with the way they were treated by most of the healthcare professionals and commented that individual professionals varied in their approach to asylum seekers, with some competent and sympathetic and others less so. Indeed, as Simret's following statement inferred, it is because of this variety that one could not generalise: *"there are some doctors and you know they do not treat you equal but not all ... there is a difference between this doctor and this doctor ... "*. Ndidi and Nkem initially appeared to agree with Simret in that their healthcare experiences had been varied because of the diversity of approaches used by different healthcare professionals: *"most of them they are nice true and they treat you well ... but some of them, they just shout at you and it is not good"* (Nkem). Notwithstanding this, the stories that they then both described, appeared to be solely related to negative experiences of healthcare utilisation because of the loud and rough, or derogatory manner in which the HCPs addressed them:

I had big pain in my back and so I go to the Health Centre for the doctor. It was Sunday and when I say I have pain for 3 days, he start shouting at me. He is shouting "Don't you know Sunday it is only for emergencies? If you have 3 days pain, it is not emergency!" How does he know it is not emergency if he does not examine me? He just stay shouting and I leave (Ndidi)

When I go to the Health Centre and say that I want to check if I am going to have a baby, they all look at me in a bad way and one of the nurses he say “how many babies do you have?” ... and even when after they say “yes, you are having a baby” ... it is like I do something very wrong ... what is wrong to have a baby? (Nkem)

These above-cited situations experienced by Ndidi and Nkem, as well as their previously mentioned reports of healthcare professionals communicating to them solely in Maltese, have resulted in them invariably attending medical visits accompanied by a professional who works with one of the nongovernmental organizations and with whom they are in contact. Ndidi and Nkem affirmed that (name of professional’s) presence at healthcare encounters did not only positively impact the way that they were treated by the HCPs but was a guarantee that they would be taken seriously and furthermore, this professional would provide them with a thorough explanation of the relevant health condition for which they were seeking care.

For Simret, good healthcare provision requires HCPs who adopt a communicative approach that enables mutual understanding: *“this doctor at the Health Centre he is wonderful ... believe me ... he talks to you too much ... he takes time to understand ... these are real doctors”* (Simret). The importance of healthcare professionals’ taking *“time to understand”* was further highlighted during an informal conversation with an asylum seeker who said *“the doctor should listen and then speak ... he needs to listen to what I am telling him and then he needs to speak and tell me what I have ... tell me about my problem ... ”* (AS, IC).

According to one of the doctors whom I interviewed, the problem with listening lay with what he perceived as the prolonged and *“roundabout way”* that asylum seekers would present their symptoms, as well as the multitude of problems that they presented with:

Sometimes ... and I am being really sincere here ... I give up before I even start because ... You allow time for them to speak, “so, what are your issues?” ... I always start with an open-ended question ... and they tell you 3 issues ... alright ... then, when we sort of arrive to a conclusion, or a semi-plan for them, they come

with 3 other issues and you have to limit ... even for me, not only for the people waiting outside ... but also for me because otherwise I'd get burnout! They take a little bit more time ... or for them to explain to you that you have a fever Oh God! "Because my body feels battered ... because I feel wrecked" ... then you realize he's got fever and cling! The penny drops and you know that you need to treat him for tonsillitis! (Tony)

This evident lack of consonance could possibly be the result of the disparity between the biomedical approach with its main focus on the medical aspects of care and which is the approach generally practiced in Malta and a more traditional one, which the asylum seekers would have formerly experienced. The cultural mediator, Iman, claimed that generally, Somalis believe in a traditional form of medicine that utilises a holistic approach to care: *"In Somalia many people go to a traditional healer and these look at the whole person and not just their body, or their organs and then he gives them herbal remedies"*. The negative impact that results from this discordance is amplified by HCPs' unquestioned belief in the superiority of 'Western' medicine and the biomedical approach, with a resultant lack of awareness of any professional obligation to utilise alternative approaches that would be in accordance to these patients' expectations and needs.

As mentioned previously, I also observed a GP clinic that caters specifically for asylum seekers and which is manned by one doctor who provides his services on a voluntary basis. The nature of the relationship between this doctor and the asylum seekers appeared to be a trusting one, with the asylum seekers seeming to willingly accept this doctor's medical advice. The nature of the interactions between the doctor and the asylum seekers appeared to be more personal in nature, which was not only a consequence of them knowing each other from previous medical encounters but also a result of the approach adopted by this doctor, who asked the asylum seekers questions beyond those solely related with their presenting medical complaint. Indeed, this doctor expressed the view that he managed to achieve a good relationship with the asylum seekers through the time he invested in *"getting to know the patients individually and who they really are"* (Doctor, IC). The asylum seekers' responses during these clinical encounters illustrated how this approach served to foster trusting relationships, such as one of the asylum seekers proudly showing

the doctor a photo of himself receiving an accolade from his employer in recognition of good work and another asylum seeker discussing potentially embarrassing and personal medical problems with no evidence of any discomfort.

As previously described, the logistics of the GP clinics at the Health Centres are not conducive to continuity of care in relation to HCPs seeing the same patients on a regular basis, because these clinics deal with 'walk ins', who go to whichever doctor is available. Additionally, during my observation period, patient files could not always be located, thus further compounding the problem of a lack of continuity, on this occasion due to insufficient organisational coordination. Notwithstanding this, whilst continuity of care can help foster a trusting and therapeutic relationship, mutual understanding can still be achieved through an appropriate and individual approach, even in the absence of inter-personal continuity as can be seen in the above examples.

In addition to HCPs showing an interest beyond the patients' medical symptoms, some of the asylum seekers' above citations further show their conviction that for quality healthcare provision, it is essential that HCPs provide them with sufficient information. Evidence from the asylum seekers' interviews and from the observational data show that the provision of adequate information was lacking: "*They informed me that I had TB and they gave me medication but they didn't tell me anything about this and I don't know anything else*" (Amiir) and this practice on the HCPs' part raises some pertinent questions with regards to ethical and clinical issues. These would include questions around a patient's right to information, the importance of being given sufficient information to enable informed consent and issues related to maintaining the status quo in prevailing power differentials. The findings related to these issues are presented in the sub-theme that addresses power differentials and control.

In Caadil's case, the lack of information impacted negatively on his ability to take an informed decision on an operation that he needed and when, as a result of the insufficient information he refused this operation, he was simply sent home with no further discussion. Caadil subsequently accepted to have the operation but only after staff at the Open Centre addressed his fears and explained the procedure in depth:

The doctor said that I needed an operation but I am afraid to have the operation. No one explained anything to me, I am afraid to have the operation here (pointing to the inflicted area) ... I told the doctor I don't want the operation and he sent me home. They spoke to me at the Open Centre and they give me information and especially when they showed me the operation on the computer I felt better and when I make the operation, I take the medicine and it is better (Caadil)

Meraf, a cultural mediator, said that a lack of information led to a mistrust of the healthcare system: “Generally there is a mistrust of the healthcare system and asylum seekers also feel that they are not respected because they are not given any explanation of what, why and how things are being done to them”. The upcoming section will present findings that show how a lack of information is just one of the healthcare practices that result in mistrust.

Mistrust and Misunderstanding

As the findings in this section will show, varying levels of mistrust were reported, as well as demonstrated, amongst both the asylum seekers and the HCPs, which not only hindered the formation of therapeutic relationships within these healthcare encounters but led to further misunderstandings and counterproductive responses. Some of the healthcare professionals' believed that the asylum seekers were distrustful of them but as can be seen from the following citation, the HCPs' descriptions of these situations did not always show clear evidence of mistrust. The nurse in the following citation was discussing how she felt that asylum seekers mistrusted what she was doing generally and her explanation for this was expressed as follows:

They want to see everything that you are doing and they ask you to explain ... that kind of thing. I don't know if they would have passed through some experience that made them have this mistrust ... or perhaps it could be where they are coming from ... they compare it to there ... I don't know if it is that they perhaps think that we do that sometimes? I don't know what it is (Miriam)

Whilst Miriam described the asylum seeker's behaviour as one that denotes mistrust, the situation is not so clear cut and appears to be related more to a lack of information giving. In contrast to Miriam's beliefs, one of the doctors reflected that he did not feel that asylum seekers mistrusted HCPs' judgments: *"I wouldn't think that there is a strong element of mistrust. After all, they trust us with their children and carry out our instructions"* (Doctor, IC). To prove his point, this doctor reported that in his experience, Somali women would never ask questions and would say yes to everything and the men were also less likely to ask questions than other patients. Both Miriam and this doctor seem to equate asylum seekers asking questions with mistrust, which could possibly reflect their adherence to a patriarchal medical system, wherein patients are expected to trust medical expertise blindly, especially if this expertise is based on 'Western' knowledge.

This doctor additionally said that "mistrust" could arise from asylum seekers' past encounters with certain doctors, based on whether the outcomes of these encounters were satisfactorily resolved: *"Because these sometimes you know, they see the same doctor ... so if with me they did well, then alright ... if for some reason they had something that dragged on or ... the outcome wasn't successful, then they become wary of you"* (Doctor, IC). Another added that asylum seeker "mistrust" is generally directed at an individual doctor, who might not care for his, or her patients. Ouma, one of the cultural mediators, spoke about how the asylum seekers who had learnt the system would check which doctors were available and if any of the ones that they mistrusted were on duty, they would leave and come back another time: *"by now some of them know how it works and when they come they ask which doctor is working and if it is one they know they cannot trust, they go and come back another time"* (Ouma). On answering my question about what helped develop asylum seekers' trust of HCPs, Ouma said it was the approach that the healthcare professionals would use with their patients: *"showing interest and treating as human beings"* (Ouma). This attitude was lacking during one of my observations when I was sitting in the waiting room that was full of mainly black asylum seekers. A patient came out of the clinic and after a short while the doctor came to the door, looked out and around and gruffly said, "Anybody?" in a very disapproving tone and with a frown on his face. The impression he gave was so much one of displeasure that a Maltese patient turned

around to her friend and said in Maltese “*he really doesn’t like them this one*”. Even if this was not actually the case, the impression had been made and the asylum seeker who was the next patient reluctantly stood up and walked into the doctor’s clinic. The migrant’s hesitancy and doubt were clear for all to see and it is highly unlikely that a positive doctor-patient relationship could develop from an encounter that began in this manner.

Another doctor claimed that mistrust on the part of the asylum seekers also occurred when these were brought to the Health Centres from detention because of the precarious relationship between the migrants and the soldiers and when entering the clinic with the asylum seeker, the soldiers would give information to the doctor in Maltese:

Those who come with the soldiers ... before I even speak to the patient it starts because the soldier would have spoken to me in Maltese as they were coming into the room ... of course ... of course ... they think that because of this, I am colluding with the soldier, which is not the case. Because let’s say, the majority of times, those who are in the position of responsibility give a fair account of the problem ... but what the asylum seekers see is that I am part of the soldiers (Tony)

Whilst Tony showed an awareness of the potential for this practice to result in mistrust, he did not seem to conceive that asking the soldiers to relay this information in English was an option, despite this action possibly allaying some of the asylum seeker’s suspicions of collusion. A later statement possibly explained the cause for this omission when the same doctor reported how he believed that occasionally, the asylum seekers in detention would make up their symptoms as a means of getting away from detention for a short while. Based on this belief, part of this information-giving between the soldier and him was to impart these suspicions, thereby giving credence to the asylum seekers’ notions of collusion. Tony recounted what the soldiers would say to him: “*Doctor, this one is wasting our time ... okay ... and 99.9% of the time it’s right ... then another time ... listen, there is something very wrong with this one ... and there would be*”. Paradoxically, Tony further described how he would occasionally tell the soldiers that the asylum seeker was suffering from something, irrespective of whether he was or was not, to ensure that the asylum seeker did not get into trouble:

Often ... often ... I told the soldiers that this one has something, when in reality he has nothing because then he would have been given a knock on the head on their way back ... oh ... they should be pitied don't you think? These are locked up in closed centres ... I mean they would need to get out ... so at times I technically lied a little bit to help out ... why not? (Tony)

Just as asylum seekers find out about healthcare services from each other as will be seen in the next chapter, Jamaal, a cultural mediator reported that asylum seekers would also discuss their experiences of medical encounters, which Jamaal said would be embellished as these stories spread from one person to the next:

Migrants speak amongst themselves and gossip a lot, adding untruths to the story as they go along and often talking about an experience as though it were their own, when in fact, they would have heard about this from a friend of a friend ... and this would have been embellished as it moved along (Jamaal)

Meraf, the cultural mediator who was previously mentioned, similarly said that asylum seekers' trust of HCPs and the healthcare system was steadily getting less because of hearsay and a growing belief that there was discrimination:

It's about trust ... the trust is less ... they think that they are being treated differently. There was more trust in the earlier days but then they started speaking between themselves and the mistrust spread ... in their mind it becomes ... because we are migrants (Meraf)

One of my observations at a Health Centre demonstrates the potential for creating a feeling of discrimination on the part of the asylum seekers, which could be easily amplified within the wider community. Attendance to the specialist clinics at the Health Centres is by appointment and a couple and their one week baby turned up at the postnatal clinic with an appointment that had been given at the hospital and mistakenly dated five weeks earlier than it should have been. Neither partner could understand, or speak English or Maltese and there was no cultural mediator available. Attempts were made to explain to the parents

that it was far too early for a postnatal follow-up but neither of them could understand what was happening. A new appointment was made for 5 weeks and they were asked to come back on the new date, which was written on the appointment card. The couple just stood there holding the baby and looking totally bewildered until they were shown to the door and they left the clinic, with no idea of why they had not been attended to. From this example, one can see how perceptions of discrimination and mistrust in the healthcare system could arise from an avertable error, with potential ramifications on the patient's future healthcare behaviour and additional damage, if the couple recounted their experiences of this event, to other asylum seekers.

Whilst the wrong appointment described above was the result of a mistake, a few of the asylum seekers did narrate stories of times when they were exposed to racist and xenophobic acts in the community. Ndidi described a situation where a bus driver started shouting at her and repeatedly told her to go back from where she came:

"I was standing on the bus and he was telling me in this rough and horrible voice 'move back you ... move back ... don't you understand ... just move!' ... I told him that he couldn't speak to me like that and he just started shouting at me and telling me to go back to where I came from... shouting like a madman!" (Ndidi)

These instances of racism and xenophobia can potentially act as a confirmation to asylum seekers that they are generally viewed as a burden on Maltese society. In this context, a feeling that such sentiments would impact on their healthcare through discriminatory behaviour would not be an unreasonable assumption for these asylum seekers to make.

Simret provided an example of what he perceived to be different and inferior treatment of asylum seekers when he explained how some doctors prescribed drugs that needed to be bought, as opposed to drugs that were given free from the government dispensary. Simret, a father of seven children, describes his feelings of humiliation when faced with this situation and further reported how he would ask the doctor to prescribe medication from the government pharmacy and would be refused, or told yes and then on arrival at the pharmacy he would be told that the required drug was not stocked:

The doctors they tell me “no, we don’t have this one, go and pay from outside!” One day I don’t have money and I say “Why don’t you give me something from the pharmacy?” Mostly he tells me “no” but sometimes he tells me “okay ... okay” and he gives me paper for the pharmacy... when I go to the pharmacy they say “no, go any pharmacy and pay from outside” ... most of the time I don’t have money enough ... You know I feel shame sometime... I don’t want to tell him ... but one day I tell him “I don’t have money ... I don’t have enough money” (Simret)

Asylum seekers are entitled to free drugs that are provided by government pharmacies on the presentation of a specific prescription, but the choice of these formulary drugs is somewhat restricted. During my observation, the doctors would occasionally write non-formulary drugs and advise the asylum seekers to buy these. The doctors would tell me that this was necessary because in these specific cases, the drugs that they prescribed were more effective than the formulary ones. Whilst the rationale that the doctors provided for this practice was somewhat justifiable, it was not all of the doctors who explained the situation to the asylum seekers and who asked the asylum seekers whether they could afford to buy the medication. At other times, doctors were unaware if the necessary drugs, such as flu medicine, were available but they would still write these on the formulary prescription sheet and tell the asylum seeker to go to the government pharmacy. This lack of essential knowledge on the doctors’ part would make it difficult for the asylum seekers to acquire the necessary medication resulting in potentially undesirable outcomes.

Simret believed that the doctors’ practice of asking asylum seekers to buy their medication, irrespective of the fact that they were entitled to free drugs, was solely because of them being asylum seekers. There seemed to be some ambivalence in his approach to this issue because whilst in the citation above he vented his frustration of this practice, in the following citation, he shows awareness and some understanding of the public discourse and sentiment that he believes influenced the HCPs’ behaviour:

I think you see the problem is the refugees. Sometimes they are given pills and they take one, or two and they throw the rest away, or just take them home and

leave them there. This is very bad and a waste ... Maybe the doctors don't prescribe medicine because of the waste, or I don't know but maybe because the refugees is a lot now in Malta and Malta is very small believe me ... and Europe do not take any of the refugees, so perhaps the Maltese do not like to think the refugees are taking free ... Sometimes when you see who is sitting in the Health Centre, maybe one or two is Maltese, the others it's refugees (Simret)

During an interview with one of the doctors, it transpired that there was a measure of truth in Simret's perceptions as described above, at least where this particular doctor was concerned. This doctor felt that similar to Maltese patients, asylum seekers tended to abuse of their entitlement to free medication⁸. In reaction to this belief, she encouraged those who she thought looked affluent to buy their own drugs by telling them that these were better for them:

The immigrants as you know, they have free drugs ... but when I see someone very well dressed ... believe me, the brands that they have, I never buy anything of those brands ... the mobiles that they have ... the latest ... the latest ... both him and her ... I am talking about a mobile that costs over 600 Euros and they ask for free medicinals! I try to convince them "the government has this but this is not the drug that I was going to give you, this is much better." "Really? It's good? So I'll buy that one" ... So 2 minutes ago you didn't have the money and now you have the money to buy the medicine? Perhaps like you have the money to buy the mobile and the designer clothes ... I don't do this with the immigrants only, also with the Maltese (Anna)

The observational data and some of the interviews such as that above are indicative of an attitude of resentment and some hostility towards asylum seekers generally. Although this was not always explicitly mentioned by HCPs in the interviews, comments made during

⁸ At the time of data collection, despite a lack of a migrant health policy, asylum seekers were entitled to free medication and whilst this entitlement was supposedly revoked if the asylum seeker started working, it did not appear to happen in practice. For Maltese nationals, the entitlement of free medication is dependent on means testing but the trustworthiness of this test is viewed with great suspicion by a substantial number of the general public.

discussions with a substantial number of them suggest a derogatory attitude towards asylum seekers. In particular, HCPs frequently referred to what they perceived to be a discrepancy between some of the asylum seekers' lifestyles and their supposed economic status. During many a discussion, comments such as *"you see them walking around, all of them with these fancy mobiles"* (Nurse, IC), or *"Huh! Don't you remember that guy who came for the nebulizer? He was wearing Nike shoes!"* (Nurse, IC) were repeatedly voiced. This attitude was evident in observation in the GP clinic, when an asylum seeker answered, "yes" to the question of whether he smoked cigarettes and the doctor turned to me and said in Maltese *"I really wish to know where they get their money from"* (Doctor, IC).

As can be seen from the above and running parallel to public opinion as demonstrated by public discussions, verbal exchanges in the streets and comments on newspaper and social networking websites, I experienced what seemed to be resentment on the part of some of the healthcare professionals towards those asylum seekers who did not exhibit signs of extreme poverty. The image of African people as poor and needy is well entrenched in Maltese culture. Prior to the era of migration, the image of black people available in Maltese society was largely derived from pamphlets that were produced and distributed by the missionaries to collect money for their work in African countries. These pamphlets would contain information and pictures, some of which were distressing photos of emaciated "black" children covered in flies and sick "black" people lying in filthy surroundings. Additionally, most village shops would have collection tins encouraging everyone to give money for these 'poor' people. To this day money is still being collected for the missions and whilst the Maltese generally seem willing to send money abroad, this generosity does not seem to stretch to include the asylum seekers here in Malta.

The healthcare professionals' resentment of migrants is further fuelled by misconceptions as to what the asylum seekers are entitled to in terms of social benefits, with some erroneously believing that these migrants receive more health and social benefits than Maltese nationals. During a general discussion about asylum seekers that I was having with some HCPs in one of the Health Centres, one of these nurses said that a close relative of hers had to stop work because of a disability that he had sustained following an accident. She indignantly asked whether it was fair that this relative, who needed to sustain

his family, was receiving an inadequate disability pension, while the asylum seekers were being given more money, as well as extra benefits such as free mobile phones and credit for calls. Apart from holding an erroneous notion of what benefits the asylum seekers were entitled to, this nurse also strongly believed that benefit allowances were so low because of the “economic burden” that the asylum seekers placed upon the country: *“so tell me ... is it fair that because we give them so much, there is so little left for my (type of relation). He has worked hard and paid taxes all his life ... what have they given or done for the country?”* (Nurse, IC). Ignorance of the specific health benefits that the asylum seekers were entitled to was common amongst the majority of HCPs and in the absence of a migrant health policy, this resultant lack of clarity appeared to fuel further misconceptions.

A general lack of trust of migrants was also evident in a large number of the conversations with doctors. These doctors reported that they sometimes felt that asylum seekers would come to them with a fixed idea of what medication they needed and would exaggerate or lie about their symptoms to be prescribed this medication. As this doctor said;

Before I used to believe everything that they told me but ... in a way they know what you are looking for ... so now I started doing things differently, I use words in a different way. “So what do you have? What are you feeling? Do you have catarrh? And if you do have, what colour is it? I ask them these open-ended questions so then I will say “ listen you said that you don’t get sputum, you just have this cough with no chills, rigors, or fevers, so you don’t need antibiotics. They protest about this because even for a simple URTI (upper respiratory tract infection) they want antibiotics (Anna)

There is evidence in the data of discordance between the health beliefs and conceptions of HCPs and asylum seekers. One example of this concerns the issue of medication. The majority of the healthcare professionals reported that asylum seekers were “*obsessed*” with wanting antibiotics, or some other form of medication to be prescribed, even when this was not indicated:

There are times when I am sure that the patient doesn't have anything ... I am not talking about those times that I am questioning ... no ... its when I am pretty sure that he is healthy ... I'm certain and you are forced into giving him panadol, or something like that ... as long as he has been given something (Doctor, IC)

Whilst the doctor cited above did not provide any explanation for these expectations on the asylum seekers' part, Tony, one of the doctors whom I interviewed, said that in addition to asylum seekers expecting antibiotics, he met asylum seekers who would prefer injections and claimed that Malta had been through this in the past. Providing yet another instance of "Othering" and doctors' perceptions of the advances achieved by 'Westernised' medicine:

I met people who would prefer having an injection and I told myself ... so this is a time warp ... Malta... 40 years ago ... when you have to have an injection over there for it to work, not a pill. Do you understand? (Tony)

Conversely, the asylum seekers would describe encounters when the doctor did not perceive them as ill, or provide them with the medication that they felt they needed:

Sometimes you know that you are sick because you know yourself, not like the doctor. He takes all the investigations and then all he tells you is tonight drink 2 glasses of water and I leave the clinic. I get angry because I know that I am sick and what has the doctor written for me to take? Water! (IC)

An example of the discordance as cited above is also evident in one of the encounters that I observed. A patient reported difficulty in breathing and a feeling of suffocation, for which he asked for medication. His file showed that he had come to the Health Centre a few weeks previously with the same symptoms but his chest and upper respiratory tract had been found to be clear. Again on this occasion no abnormalities were found on examination and when the doctor told him that his chest was clear, the patient added that he had blood in his urine. A urinalysis also proved to be negative and the patient started arguing with the doctor and telling him "you don't want to give me what I need ... you are not a good doctor!" (AS, IC). The doctor tried to explain and then decided to take some

blood tests to confirm his diagnosis but the patient refused these and angrily got up and left the clinic. I did not have the opportunity to discuss this patient with the attending doctor any further and therefore do not know whether the possibility of this patient suffering from somatisation had been considered, although a lack of any form of psychological assessment, or referral to psychological services tends to negate this. In any case, for both the doctor and the asylum seeker, the encounter helped foster the cycle of mistrust.

During my observations, I encountered other asylum seekers who refused blood tests and Meraf, a cultural mediator, provided two possible reasons for this. He suggested that Africans, especially Somalis, were afraid of having their blood taken because they believed that they could '*bleed out*'. Secondly, he said that some migrants believed that some investigations and procedures were carried out unnecessarily to provide opportunities to train students. This is a further example of how a failure to provide the required information about the nature and necessity of procedures on the part of HCPs, results in a mistrust of both HCPs and the healthcare system.

An asylum seeker I met during observation said: "*They take my blood and they are happy with it and say that is good and then they want to take more blood. Why do they want more if it is good?*" (AS, IC). This asylum seeker had originally come to the Health Centre complaining of flitting joint pains which he had been suffering from for 3 months but which had worsened in the last 3 weeks. He had been seen twice previously at the Health Centre for the same symptom and had some blood tests taken which were normal but he was still in pain. During this last visit, the doctor explained that he needed an X-Ray and another blood test to rule out rheumatoid arthritis. The patient replied that he would take the X-Ray but not the blood test because the previous session of blood letting had already made him very weak and asked the doctor to give him some medication instead. The doctor refused to do this without a confirmed diagnosis and so it was yet another encounter that resulted in a disgruntled patient, a frustrated doctor and a tenor of distrust.

Whilst some of the asylum seekers spoke about unnecessary tests being taken, the doctors reported that there was a certain amount of over investigation carried out with the asylum seekers but further explained that this was because they were afraid of missing out on

something important. So whilst the following citation is an example of good practice, the absence of effective communication with the asylum seeker to convey the need for further investigations, could have a negative impact on future issues of trust:

Somalis, they are obsessed with kidneys ... kidney stones and the liver ... so anything that happens, they immediately tell you because my back is hurting me ... so I start thinking but can it be that this person has hydronephrosis, or something like that? And these poor things would be coming ... you know all that travelling ... but you can't just snap your fingers and get an ultrasound done, so you think but if I miss a hydronephrosis he is going to end up with renal failure ... so you say, lets carry out a urinalysis. Now if I see the equivalent in a Maltese patient, I wouldn't even do that but maybe because of their history ... or perhaps the way they tell you things, or they might miss out on something... (Tony)

HCPs also appeared to mistrust the asylum seekers' responses to questions related to lifestyle. So much so that during my observation there were numerous times that the asylum seekers answered a question with "no" and the doctor asked "are you sure?" During one encounter that I observed, the doctor asked the patient whether she was pregnant and despite the fact that the patient answered "no, I do not know man", a pregnancy test was still ordered.

The majority of the HCPs appeared to disapprove of the many children that they purported that asylum seeker women had and suggested that sessions are organised to educate them about planned pregnancies:

They need to be educated about these things, do you understand? Because these, if they cannot afford a certain amount of children ... like we were educated about these things, even they need to become aware of them ... so they won't continue in the same way ... even healthwise, it's for them as well (Joseph)

The following racist statement was made by one of the doctors:

Women always ... I don't trust them ... I always do a pregnancy test ... always because I don't trust them. In fact I heard this from an old man who said, " they are a factory ... they are a factory that produces babies and it's true ... you always see the women dragging children behind them ... always (Anna)

As the above data demonstrates, in the majority of cases, the healthcare professionals exhibited an ethnocentric and 'Othering' approach in their encounters with asylum seekers and this will be elaborated upon in the discussion chapter. This attitude was not confined to the issue of health beliefs and healthcare but was also evident in relation to the lives of asylum seekers generally. During an informal conversation, one of the nurses described in a deprecating way what she would 'find' when visiting migrants at home for work purposes:

I have been in these peoples' homes and I always saw disorganization, dirt, a large group of people all over each other, smells and ... without wanting to you say "how am I going to integrate with these people?" ... they always showed me respect you know ... but their lifestyle I think ... no, not I think, I know ... is totally different to ours and I don't feel ready to ... unless they can adapt to our lifestyle (Nurse, IC)

This nurse appeared to give no consideration to the possibility that the overcrowding could have been due to the asylum seekers' impoverished circumstances. Instead, she automatically put what she considered to be the migrants' objectionable behaviour down to "their lifestyle".

Other healthcare professionals did address the socio-economic circumstances of the asylum seekers' lives: "So more than education about hygiene, it is more of a case of making sure they have the amenities" (Maria) but still, the need to teach the asylum seekers certain 'Western civilized' behaviours was evident in some of the clinical encounters that I

observed. This paternalistic approach served to place these healthcare professionals in an even stronger position of power during the encounters.

Power Differentials & Control

Both the interviews and the observations provided evidence of the complexity of the power differentials at play during the clinical encounters between asylum seekers and healthcare professionals. The majority of encounters were conducted within a strongly ethnocentric and paternalistic framework, in which power was clearly wielded by the professionals:

I think that there are some who still don't know the system ... but it's not only that ... they have a lack of education and this could affect their health and health behaviours. So it's important that you try to teach them the system and also how to look after themselves and you teach them as though they were children ... even with pictures and making it as simple as possible so that they could understand it ... as I said, just like you would with children (Joseph)

I also came across this form of infantilisation and need to teach 'the uneducated' during my observation. On one of these occasions, an asylum seeker visited the doctor and was diagnosed with an upper respiratory tract infection. He asked the doctor for a sick leave certificate and when he told the doctor that he had only been working in his present job for a few weeks, the doctor gave him a whole speech in a very patronising tone about why he should not miss too much work because his employer would end up not liking him. Whilst it appeared that the motivation behind this speech was well intended, it showed that the doctor's perception of the asylum seeker was one of a person who was totally ignorant of work ethics. On another occasion, there was an asylum seeker who was having a wound being dressed in the treatment room. The nurse who was dressing the wound asked the man, who must have been in his twenties, whether he had a girlfriend and when he answered that he did not, she started teasing him and saying that she was sure that he had a girlfriend because she had seen him with a girl, speaking in an infantile manner solely used for children. During my period of observation, I have never seen this nurse behave in a

similar manner with any Maltese persons, suggesting that this behaviour was a consequence of perceptions of asylum seekers possessing a child's mentality.

Instances of ethnocentricity and 'Othering' were also evident in the interviews, as can be seen in the following citation:

There is the issue of them not knowing how to cope with things ... even simple chores ... they need to be taught a lot of skills but at the moment I can't think ... erm ... you will say that this is a racist comment but it's not a racist comment ... there are even a few Maltese who do this. Blowing their nose, damn it! They don't blow their nose (mimics blowing and bringing up phlegm) ... the Somalians for example, when they say yes they do this, which we Maltese see as rude (mimics clicking sound with the mouth). You ask yourself "what on earth are they doing?" and when I asked the translator, I was told that they're saying yes ... Oh okay ... all right ... but I ... erm ... it's not done ... (Tony)

The ethnocentric attitudes demonstrated above, in conjunction with a biomedical approach and a lack of communication support, clearly promote unequal power relations during clinical encounters, with the migrants being relegated to a subordinate position. Meraf, a cultural mediator, referred to HCPs' lack of acknowledgement to any other forms of knowledge apart from 'Westernised' knowledge, when he said: "*different cultures have different types of knowledge but the doctors do not take any notice of what we know ... it is only their knowledge that they think is good*" (Meraf). Additionally and as mentioned previously, asylum seekers are generally not given sufficient information and Meraf explained how this results in them being unaware of both their rights and their responsibilities within the healthcare setting:

The lack of information is not a problem of a lack of cultural mediators because these only translate what has been said, so if the doctor says "operation ... sign for operation", then this is what the mediator will tell the patient. The thing is that migrants do not have the confidence to ask for information, perhaps because of past experience, or from what they have heard through the grapevine ... Also, some

believe that it is not polite to ask, or they do not have enough knowledge to ask ... what are the migrants' rights and responsibilities? They don't know what they have to do ... (Meraf)

During my observation it was clear that over half of the asylum seekers refrained from questioning the HCPs for further clarification but in contrast to some of Meraf's words above, in the absence of linguistic discordance, the amount of medical information given to asylum seekers was dependent on the individual healthcare professional. Generally, when the asylum seekers could understand and speak English or Maltese, or a cultural mediator was available, more information was offered. However, even in these cases, I observed a general lack of civility on the part of some of the healthcare professionals, such as passing comments in Maltese, or interruptions during the encounters and failing to excuse oneself for these, which in turn served to reinforce the power imbalance.

As can be seen from the above, the majority of these encounters were carried out within an ethnocentric framework with the healthcare professionals assuming a position of dominance. Notwithstanding this, there were instances when the asylum seekers challenged this power imbalance. During both the observation and interviews it was possible to record examples of resistance to medical dominance and ethnocentrism, through instances where asylum seekers attempted to retain some measure of control over the encounter. However, in this context, where it is the HCP who controls the consultation, these attempts were mostly unsuccessful and for some of these asylum seekers, ended in rejection, as the following example demonstrates:

Basically what happened was that this colleague (doctor) of mine, instead of saying "take a seat", she said, "sit down" ... "You don't speak to me like that!" he told her, "you don't speak to me like that because I am black!" ... Now this happened in February, so she probably had a very busy clinic and she told him, "so you speak to me like that because I am white? No, go out, I won't see you, find another doctor ..." (Nurse, IC)

Another strategy that asylum seekers utilised to challenge the power imbalance and resist the dominance of the HCPs, would be by not complying with medical advice and prescribed treatment. Ouma, the cultural mediator, described how, on leaving the clinic, a few of the asylum seekers would state that they did not trust the doctors' judgment and would therefore not be following their advice. Ouma additionally reported that this response on the asylum seekers' part would generally be a consequence of a medical interaction wherein they perceived the HCP as utilising an inappropriate authoritarian and biomedical approach.

According to the female health care professionals a power struggle would occasionally occur when they were tending to some of the male asylum seekers who, they argued, believed women were inferior and therefore would not want to be treated by a woman': *"The men even a simple cut ... they look at you and you can see that they are thinking "Oh no! A woman!"* (Mimics asylum seekers' horror of being seen by a woman) *and then they try to put you down ... but that is until you've treated them once and then after that they are okay"* (Maria). This is yet another example of 'Othering', with experiences of the behaviour of some men being extended to represent 'all men'. 'Othering' is again clearly evident in the following citation, which was voiced by a female doctor who ascribed these misogynistic attitudes to *"the Libyan men"*:

Just because I'm a female, the Libyan men especially, they don't like it and they start acting really stupidly ... they look at you in a way as though you're nothing and it's as though they are saying " huh! A woman! I am going to be seen by a woman!" ... they try to make you feel small but I fight it ... I don't let them (Anna)

As can be seen from the above, any behaviour on the asylum seekers' part that challenged the authority and dominance of the HCPs resulted in an adverse response from the latter, possibly serving to foster further feelings of helplessness amongst the asylum seekers in a world over which they already had so little control.

Summary

The findings associated with communicating within the healthcare encounter that emerged from the data and as presented in this chapter, illustrate the variety of factors that impact on cross-cultural interactions.

Linguistic discordance was cited as the biggest challenge by all but one of the HCPs. Doctors especially voiced the potential undesirable outcomes of this, which included asylum seekers' unmet needs, dubious ethical practices and legal repercussions. The asylum seekers' attitudes towards linguistic discordance were varied, ranging from some reporting that this was not an insurmountable problem, to others attesting that it created a major barrier. The variations in responses appeared to originate from past experiences of healthcare systems and present circumstances, such as being overwhelmed by other more pressing problems. Irrespective of all the participants' responses to linguistic discordance, the findings that emerged from the data showed how this often resulted in a lack of mutual understanding, with all its associated risks on health, healthcare practice and future healthcare behaviours.

"Their culture" was also touted by the HCPs as a reason for discordant healthcare encounters and lack of mutual understanding. The HCPs' notions of culture were generally essentialist and the findings provide evidence of the HCPs' unwavering conviction in the superiority of all things 'Western', leading to 'Othering' practices. As a result of this perspective of 'Western superiority', the majority of the HCPs tend to place the asylum seekers on a hierarchical scale, with those asylum seekers possessing more dissimilar characteristics to themselves being placed on the lower rungs of this scale. Additionally, the HCPs' perspective resulted in a failure to question the validity of the dominant biomedical model of care, which is incongruent with many asylum seekers' expectations of a holistic approach to care, resulting in mistrust that in turn puts further strain on these encounters.

The following chapter will demonstrate how cross-cultural healthcare interactions are shaped by a variety of external forces that impact on healthcare access, utilisation and provision.

Chapter 6: Seeking Resolution

Introduction

This chapter presents the data related to the healthcare journey through three sub-themes namely “Finding the Way”, “Providing Care” and “Needing Support”. The findings show that whilst the asylum seekers and HCPs have a common main goal, which is to achieve a satisfactory resolution of the presenting problem, there are a myriad of factors that obstruct the participants from reaching this goal. These factors, which are an accumulation of past and present experiences and events, impact on every facet of the healthcare journey in the way that they shape the participants’ diverse expectations, perceptions and behaviours, which are then subconsciously brought to the healthcare encounters. The term chaotic bricolage provides a lucid image of these healthcare encounters, as the participants attempt to seek some form of resolution through the complex interaction of diverse and often discordant factors.

Finding the Way

As mentioned previously, the asylum seekers would learn how to access the required healthcare service either from other asylum seekers: *“I learn about the health services from other migrants ... that’s how I learn. You say your problem and they tell you what to do”* (AS, IC), or from the staff working with relevant NGOs, or at the Open Centres:

Before I had a problem with my eyes, so I go to Floriana and they check me ... I knew where to go because I speak with my social worker and he tell me ... it is not a problem. Anything you can speak with the social worker, or the care worker and he is telling you where to go and about everything (Akram)

According to one of the professionals who works directly with asylum seekers, the understanding of, and ease with which migrants access services, is also dependent on their level of education. Indeed, despite Akram’s assertions of being able to get all the required information, there were numerous instances where I could observe asylum seekers

accessing services incorrectly. These instances included migrants coming on the wrong day or without an appointment for one of the specialist clinics, or for a service that was not available, or coming to the wrong Health Centre in relation to the location of their residence. Instances of these errors were also evident during the interviews:

When they sent me home from the hospital after my baby they did not tell me to go to the well baby clinic and I only find out about this service when I went to the Health Centre to ask about the vaccinations for my baby (Sabo)

I learnt everything about the healthcare system when I was at the Open Centre because the staff there told me everything ... but at the beginning I cannot understand everything and I went to the wrong clinic they tell me “you are not here, go to ...” (Caadil)

I asked around and other people told me that if I was at Hal Far, I should go to Floriana. I had just left and I was living in Bugibba but I wasn't aware that there was a clinic in Mosta, so I went to Floriana (Amiir)

In these situations, the first people that the asylum seekers would encounter would generally be the receptionists, with responses to these situations varying according to which receptionist happened to be on duty. Notwithstanding this, in the event of linguistic discordance, the majority of the receptionists would raise their voices in the false notion that this would enable understanding, regardless of the topic and the fact that they could be heard by a waiting room full of people. Furthermore, whilst most of the time the receptionists would patiently try to impart the relevant information, there were a few times when the frustration of not being understood by the asylum seekers was evident in the receptionists' tone and manner, with their frustration being misguidedly aimed at the migrants, as opposed to an administration that failed to provide the adequate resources. Such behaviour could potentially result in asylum seekers' healthcare needs being left unaddressed, either from failing to understand the instructions, or because they were discouraged from returning due to what they felt was an undesirable experience. Simret recounted what for him was a very humiliating experience and as a result of this, refused to

return to that specific Health Centre again. Simret was shouted at by a doctor for attending a Health Centre on a Sunday for a condition that was not deemed to be urgent:

I feel very bad in my stomach because I was vomiting. Anyhow I came on Sunday and I say to the doctor "I feel very bad since 2 days ago". He started shouting "Now why your people you do not understand? Saturday and Sunday for emergency, come tomorrow! Please don't use my time there is a lot of people outside" ... Nobody's outside ... I feel very bad ... he did not have to speak to me like that ... I feel very bad ... (Simret)

In the case of asylum seekers coming to the Health Centre from the wrong catchment area, receptionists would mostly accept them to be seen with a warning to go to the correct Health Centre the next time. Whilst these asylum seekers all said that they were unaware that they should have gone to another Health Centre, most of the HCPs did not believe that this was the case and made no attempt to hide their disbelief from the asylum seeker. However, the HCPs would generally agree to tend to the asylum seekers' medical or nursing needs, repeating the warning for them to visit the correct Health Centre the next time. In these situations, the majority of the healthcare professionals appeared to feel that they were going out of their way to be helpful and would get more upset than usual, if these patients did not then show their gratitude, or were perceived as being non-compliant. As this doctor angrily recounted:

He knocked on my door and I thought "oh well, let me see him once he is here" and I saw him. It was a serious case, he was risking losing his eyesight and he used to go to (Name of Health Centre) where they used to give him antibiotics and more antibiotics and he was pending an operation. He told me "I'm just here for eye drops" and I said "no" and explained, "you have a serious condition and you are risking the operation being cancelled. The treatment that you are having is not enough. You need to be seen by an ophthalmologist and I will write a referral ticket for you to be seen by this specialist in hospital" ... He started shouting at me and saying "you're not a good doctor! You won't give me my medicine! You won't see me because I'm black!" And there I was, not only was I doing the right thing

medically but I had even accepted to see him when he shouldn't have been here. I was really angry! He was so loud that the receptionists came in and they also told him "This doctor accepted to see you and then you talk to her like that!" (Anna)

This doctor further stated that due to the above-mentioned experience and another one similar to this, her opinion and attitudes towards migrants had changed:

I was having a discussion with a colleague and we were saying how some of us have become racist ... I must say that my view has changed on black people, completely. Before I used to be very tolerant and try to help them in all that they need ... but through two experiences that I have had ... I am really changing (Anna)

Despite Anna acknowledging that she had also had positive experiences, measured mostly by being shown gratitude: *"there are some of them who are nice and appreciate what you do with them and everything but still ... some people ..."*, she appeared to ascribe the negative behaviours that she experienced during two incidents to be representative of all the asylum seekers. Similar reactions were also evident in some of the other healthcare professionals and although a few of these did try to determine an underlying cause for what they viewed as inappropriate behaviour on the part of the asylum seeker, the majority ascribed these undesirable attributes to migrant characteristics generally.

As mentioned in a previous chapter, the asylum seekers would often adopt defensive behaviour because of mistrust in the system and whilst Dr. Anna insisted that the sentiments that she felt towards asylum seekers did not have a negative impact on her care provision, the combination of these factors could hardly be conducive to a successful healthcare encounter, which would in turn serve to further confirm the key players' preconceived negative sentiments.

Notwithstanding this, there were some healthcare professionals who showed empathy towards what they imagined would be the asylum seekers' apprehension as regards their visit to the Health Centre:

Obviously, when they come for that first time they are apprehensive here till they are seen. So the way that you greet them is important ... you have to be a little ... a little more careful and you have to understand their situation and their fear
(Joseph)

Another nurse remarked on the reticent behaviour of some of the asylum seekers:

I notice that there will be some who just remain in a corner ... hush, hush ... just like that. All they do is follow you with their eyes and I'll be thinking, "Just tell me! Is there something that I can help you with?" Then after nearly an hour or so he would tell me "listen because I need this ... or I need that ... or I have a pain here". Now why didn't he just say this before like other patients? It's as though they are afraid or something (Maria)

Nonetheless, irrespective of this acknowledgment of the asylum seekers' apprehension and fears, the latter seemed to be expected to blindly accept any medical advice given and not question the healthcare professionals' medical judgement:

As soon as the patient comes in I can tell "with this one there are going to be problems". You can tell the way he is ... he keeps asking questions before you even finish and sometimes he even disagrees with you ... even the Maltese you know
(Nurse, IC)

During observation, there were instances when these expectations were evident and whilst most healthcare professionals were very patient with providing necessary information and instructions to the asylum seekers, a few of these clearly showed their disapproval if their medical judgement was challenged in any way. The responses to this disapproval varied, with some migrants responding angrily like the doctor's citation above, whilst others became subdued and changed their approach in subsequent encounters: *"he became angry because I wanted to know why he did not give me medicine, now when I go to the doctor I stay quietly ... I stay quiet"* (AS, IC)

The HCPs' accounts of the asylum seekers' helpseeking behaviours, referred to a variety of patterns that ranged from asylum seekers' accessing the primary health care services for the slightest of reasons to delaying access, with the latter being the most commonly cited:

With them, even really minor symptoms like a little abdominal pain that we would definitely not go to a doctor for ... they always come to the health centre. I think that the reason is that in their country of birth they did not have easy access to healthcare, so once they come here, they have this free access to healthcare and so, it seems that every chance and opportunity that they have, they go to the doctor
(Anna)

I don't think that they come to the doctor that much, although they do come with their children because I see them ... but not that much ... they need to be sick ... pretty sick. In fact, I think they delay coming with them because often they would have had a fever for quite a while and such, so I think that they take sometime to bring them to the clinic (Miriam)

According to another nurse, asylum seekers delayed going to the Health Centre because of a lack of awareness of the available services:

Often they come late in the illness because they wouldn't know ... they wouldn't know and I would tell them "It might be that you didn't know about this service here in Malta with free medicine and healthcare open 24 hours because it would have been better if you had come earlier" and then they say "okay, for next time". The thing is don't forget they are in a country they don't know ... they're lucky if they knew Malta even existed before they arrived here (Maria)

That a substantial number of asylum seekers were unaware of certain details about the healthcare services was also evident during observation and there were numerous times when asylum seekers needed clear explanations of how to proceed with any further investigations, or referrals and most of all, needed assurance that they would not have to pay for these services. Simret describes the benefits of being accompanied by an NGO

staff member who helped him navigate his way during a medical emergency for his one-year old child:

My son had this thing, like a balloon with water and at (name of clinic) health Centre they told me to take him to hospital ... to emergency direct and (name of NGO staff member), she is doing everything. She helped me you know because she know the way to go. I would take time to know ... this door? ... or this one? That doctor? ... or this one? I just followed her around everywhere (Simret)

A feeling of shame, or the belief that the ailment was a deserved form of punishment from “Allah”, were also cited by both asylum seekers and healthcare professionals as reasons for delaying medical attention. In fact, Maryan recounted how she was ashamed to tell her sister about the rape and only told her once she could not hide her pregnancy anymore and thus, delayed seeking medical attention:

When I find out that I am pregnant, I didn't go to see a doctor. There was a reason ... because my sister was here and I had been raped and the baby you know ... I didn't want my sister to find out that I had been raped. But when I found out that my baby was growing up and I couldn't hide it anymore, I told my sister... then I could go to see a doctor (Maryan)

Delays due to shame, or a belief of retribution were also evident in some of the healthcare encounters that I observed. Additionally, during the observation period one of the doctors recounted how an asylum seeker whom he had examined was suffering from advanced venereal disease. When the doctor asked him why he had taken so long to seek medical help, the asylum seeker said that the illness was the result of an illicit encounter and not only was he ashamed but believed that he deserved this retribution from “Allah”.

From the majority of the asylum seekers' accounts, it appeared that they visited the doctor when the symptoms started to bother them and impinged on their daily activities: “*When I was working my breath cannot come out well ... I felt very tired. So I went to see a doctor*” (Caadil)

I took a while to go to the doctor because first of all I had a wound here (pointing to his chest to the left of his heart), which was oozing. It was a small one and when I first saw it, I wasn't so concerned but then, when my throat started swelling and I began to feel weak and I lost my appetite ... that's when I called the doctor of the Health Centre to come and see me (Amiir)

Amiir was sent to hospital and subsequently diagnosed with TB, which he had suspected after having discussed his symptoms on the phone with his uncle back in Somalia. It was not only Amiir who would contact relatives in his country of origin for medical information. Patrick also said that he would telephone his mother, who is a nurse in Sierra Leone, when he needed some medical advice. Indeed, until the time of the interview, Patrick was refusing a bilateral hip replacement because his mother had told him that he was too young for this operation, despite his being advised by surgeons both in Malta and in Denmark. Patrick further felt that because of his mother, he himself had learnt about what drugs he should take for certain symptoms, saving him from having to go to the doctor:

I rarely go to the doctor ... I am not sick all of the time. Sometimes it would be four, or five years without being sick... just painkillers. Sometimes when I feel pain ... you know I go to work and work hard, I feel pain and so I take painkillers ... panadols and I would buy them myself ... because my mum is a nurse so a little bit of medicine I know ... indocid, tramadol ... all those medicine that protect you (Patrick)

Asylum seeker reports of going to the doctor when their symptoms started to hinder their daily activities were corroborated by some of the healthcare professionals, with one of the doctors differentiating between helpseeking patterns amongst East and West Africans and Syrians:

The people of West Africa are much more down to earth and practical and I think more hardworking perhaps than the people of East Africa, Somalia etc ... I'm not

really sure how to put it ... from my experience the people of West Africa would come because they would have musculoskeletal conditions interfering with their work. With a cold, I have rarely seen one with a cold ... but with musculoskeletal problems they come straight away because “I have to go to work” ... they all get sick but the illnesses that certain asylum seekers come with are different to other asylum seekers ... I am saying this from my experience ... now how do the Syrians present? They tend to come “put me back to ... I need to work”. They are focused on work too (Tony)

Whilst none of the other healthcare professionals made this differentiation in relation to nationality and healthseeking patterns, a substantial number of them did say that often asylum seekers would refuse occupational entitlements such as sick leave because they were afraid of losing their job:

A lot of them work in construction and that kind of thing ... and often they have accidents so they come here ... but let me tell you, they keep on going to work because they are afraid of losing their jobs and so, this affects the state of their wounds (Nurse, IC)

In the same vein, another healthcare professional reported that many times asylum seekers would come to the Health Centre as an emergency on a work-related injury but would not want this documented: *“These cases are coming to mind ... often they refuse for example to have an injury on duty form filled in because they start worrying that this would mean that they can’t work, or they are afraid that their boss will just chuck them out” (Mark)*. During my observation there was an asylum seeker who had a wound that needed a daily dressing and he was asked to attend the wound clinic, which closed at 5pm. This asylum seeker would invariably turn up after 5pm and when he was asked why, he said that his employer would not let him leave and even though the nurse said that he would write an official note for his employer, this migrant refused because he was afraid of losing his job. It would be relevant to point out at this stage that to date, a large number of asylum seekers are illegally employed in the construction industry through deals that are struck by the roadside. Indeed, every morning one can see large numbers of asylum seekers waiting at

specific locations on the lookout for work opportunities, regardless of the potential for abuse and exploitation as a consequence of being employed illegally⁹.

Unlike the above-mentioned asylum seeker who could not attend his appointments punctually because of an irrational employer, transport was the most commonly cited reason for migrants' inability to keep appointments. This was a trait which most of the healthcare professionals reported as prevalent: *"I don't know but they just cannot keep an appointment ... we give them appointments for nothing... perhaps difficulty with the transport? I really don't know ..."* (Nurse, IC). A substantial number of the asylum seekers live in one of the larger Open Centres that is sited in a remote location from which buses are known to be both infrequent and unreliable. Whilst Caadil did not live in this Open Centre, he blamed an unreliable public transport system for the few times that he might have arrived late for medical appointments: *"I like to keep appointments and if I am late, it is only because of the bus ... I have appointment and I keep it always"* (Caadil). Habiba, a Libyan woman whom I had met during observation and who has been referred to in a previous chapter, explained that in Libya women would never catch buses and therefore faced great problems with using the public transport in Malta, often missing appointments altogether as a result of this. Otherwise, all the other migrants who were interviewed said that they attended all their appointments punctually.

This did not seem to be the case generally when I observed the specialist clinics at the Health Centres, which are appointment based. Whilst there were a number of asylum seekers who were punctual, there were others who did not turn up at all, or turned up without an appointment. The majority of them would attend the clinic on the right day but at a later time than their appointment. Jamaal, one of the cultural mediators, believed that asylum seekers missed appointments because of perceptions of the transitory nature and impermanence of their situation: *"They do not attend appointments because they do not think that they are here to stay"*. Conversely, Iman, another cultural mediator, could not give a reason why asylum seekers, especially Somalis, failed to keep their appointments:

⁹ In a drive to clamp down on the irregular employment of asylum seekers, the Maltese government has raised fines for employers with unregistered workers and are further discussing the creation of job brokerage offices for vulnerable groups, to ensure fair and equitable employment (Borg, 2016)

Somalis especially do not keep appointments but there is no reason for this, I do not know or cannot think of any reason for this. I am not like that, I have to come to work at a certain time and I am here at that time. Some do keep appointments but most ... 60% ... do not keep and for no reason. Also, another thing is that they do not come early, always after 10am ... I think that they like to sleep because often I have nothing to do before 10am. In fact they would be here between 10am and 4pm (Iman)

Most of the healthcare professionals also commented on how the asylum seekers would turn up at the Health Centres after 10am, with very few attending in the late afternoon, or evening, unless it was an emergency.

It's amazing, at 8 in the morning you don't see many, or any really ... at 10 ... truckloads! But this is not proper healthseeking behaviour ... I mean why do they all come at 10am and then as the day goes on, less and less come ... unless it's an asthmatic attack, or something like that (Doctor, IC)

Whilst the doctor's assertion that this pattern does not constitute 'proper healthseeking behaviour' is questionable, the fact that there would be such a large number of asylum seekers at one period of time did appear to constitute a problem in relation to the extra energy and time that healthcare professionals needed to expend with these patients:

Now I am going to speak for myself ... often you get tired ... tired ... you see 15, one after the other ... problems ... you can't understand without a translator ... sometimes you can't understand with a translator... there are also other problems ... so sometimes, when number 16 comes in ... you just can't ... you're finished! You're so tired that you say "I'm just too exhausted to even care" ... it's awful you know ... (Tony)

This doctor's lament highlights the daily struggle that HCPs such as these faced as they attempted to respond to the asylum seekers' healthcare needs, often unable to understand

them and lacking the knowledge of how best to do so, because of an institutional structure that generally lacks the required resources to enable and support them in this.

Providing Care

The reality of the difficulties that the HCPs faced when providing healthcare to asylum seekers was also evident during observation. On one of these occasions, one of the asylum seekers had a potentially serious medical problem, which whilst not requiring hospitalisation, did require close follow up. The patient was living in an Open Centre and the doctor was worried that it would be impossible to keep in contact with him once he had left the clinic. To avoid this, a network was developed between the staff at the Open Centre and the HCPs at the Health Centre to ascertain continuity of care for this patient. Whilst the desired outcome had been achieved, the time spent on this one patient was considerable.

The difficulty of keeping in contact with patients who were asylum seekers was also highlighted by other healthcare professionals and one of the nurses described how because of this, a system was set up specifically for asylum seekers to enable them to be given their results after blood investigations had been taken:

Because if he is Maltese obviously we have an address where we can send his result but if we send it to one of the Open Centres it will obviously get lost, or something like that. Also, these people move around a lot and so they might not even be there. So when we see one of these immigrants we tell them “go to the reception and make an appointment with the doctor so he could give you your results in 2 weeks time” ... because if we post it to them we are afraid it would never reach them, so we devised this system for them (Joseph)

Another of the nurses who managed one of the specialist clinics explained how she would try to contact patients by phone when they failed to turn up for their appointments but the majority of these asylum seekers would never answer their phone. This was corroborated by a professional who works directly with asylum seekers and who reported how she had

lost contact with them, despite her having their mobile number, adding that they just seemed to have vanished into thin air. These accounts all serve to accentuate the migrants' transient existence and to further advance a sense of impermanence.

The heightened demands that an awareness of this transient existence placed on the healthcare professionals: *"you can never be sure that they will come back for a follow up visit, so you try to do all you can on the first visit and keep your fingers crossed"* (Doctor, IC), were compounded by the immediacy that primary care provision requires. In fact, a number of healthcare professionals explained how the nature of primary care, which requires an instant response, served to magnify the difficulties associated with caring for this cohort of patients. As this doctor said:

In secondary care people can usually wait, which is very different to primary care ... in primary care people need to be seen to there and then ... I would find it handy if I, for example could contact someone who could help whenever I needed and I could say "listen, over here in front of me I have this person etc ... (Doctor, IC)

The HCPs, especially doctors, also discussed the difficulties associated with a lack of training and knowledge with regard to tropical medicine and *"black pathology"* and further explained that there were racial differences in the way that people respond physiologically to certain conditions. One of these doctors gave an example of this through hypertension:

If you get 3 clones ... clones okay? A Chinese, Caucasian and black, an Afro-American type of black alright? So these have everything the same, that is they are clones of each other ... theoretically okay? But they have a different skin colour, otherwise, everything else is the same and they have hypertension. If they do not treat the hypertension they will get different complications. So the Asian will get kidney failure, the black stroke and the white heart disease ... there are studies that show this you know (Tony)

More knowledge with regards to female genital mutilation was also mooted as necessary, as the following citation shows: *“she had a breakdown of her episiotomy, so till I understood how it was ... it wasn’t the first one that I had seen but it still was a struggle ... I struggled to match this with this ... and that with that”* (Doctor, IC). Notwithstanding this, the most commonly cited problem in relation to “black pathology” was a lack of medical training on black skin dermatology and the associated challenges. The doctors explained how these challenges resulted from either a different presentation: *“If you see ringworm ... ringworm on black skin looks like eczema ... completely off!”* (Tony) or due to a difficulty with actually seeing the condition: *“Imagine measles ... measles ... now you tell me how you are going to diagnose measles which is macular, meaning a flat rash, on someone who is black ... you can’t!”* (Tony). In fact, one of the doctors reported how these issues resulted in uncertainty and were cited as another reason for extra investigations being carried out: *“Scabies ... how am I going to recognise scabies if he doesn’t have anything on his palm? ... because his palm is pink. This is another issue that results in overinvestigating ... because I just have no other choice ...”* (Doctor, IC).

Another doctor also referred to scabies but in her case she recounted how she would assume that every asylum seeker who would complain of itching suffered from scabies. She added that she would generally be right and referred to the migrants’ crowded living conditions as the reason for this high incidence, as well as what she claimed to be their general lack of hygiene. In fact, she further said that if a Maltese patient had to present with itching, she would not suspect scabies but would suspect some form of allergy:

If a black person comes and tells me “I’m itching’, I go straight for scabies ... I am usually right and this would be because of the economic deprivation that they live in ... a lot of people in the same place ... certain smells that they have because they do not wash ... not all ... but some ... On the other hand, if a Maltese patient tells me “I’m itching”, I would think of finding out what he is allergic to (Anna)

A connection between asylum seekers and scabies was also made by other healthcare professionals and during my observation there were numerous instances when a nurse

caring for an asylum seeker would be told to be careful in Maltese by another nurse because “*where they live is full of mites and they have scabies*”.

Another illness that healthcare professionals appeared to associate with asylum seekers, or perhaps more correctly black people, is AIDS and a significant number of doctors and nurses spoke about how they would ensure that all possible precautions were taken when dressing an asylum seeker’s wound, or when taking their blood. This was also evident during observation and whilst generally the majority of the HCPs would take standard universal precautions with all of their patients, there were a small number who would only adopt these precautions if they were attending to asylum seekers. One of the nurses that I interviewed had this to say:

Discrimination is the way that the minute that we see someone black, that’s it, gloves straight away because I think there is that taboo that they are full of disease HIV and that sort of thing ... I know that you really need to take universal precautions on everyone ... but this ... because of the colour of the skin ... you have to be really much more careful (Mark)

Whilst it is paradoxical that the above statement was made by the same healthcare professional who had previously asserted that he treated all his patients equally, the expressed sentiments are a close reflection of those of the local population generally. Indeed, that asylum seekers are harbingers of pestilence and disease and therefore, should not be allowed into Malta, is an argument that has often been expressed publicly.

When discussing discrimination in care provision, one of the doctors said that healthcare professionals tended to treat asylum seekers differently but further stressed that whilst different, this did not mean that the care provided was inferior. Additionally, he appeared to suggest that this different approach was because of certain behaviours that asylum seekers demonstrated and questioned the reason for this:

They are treated differently ... not pejoratively ... differently and this is because their responses to healthcare are different. For example, generally speaking, you

have a standard asylum seeker and he is told, “tomorrow come to have your dressing changed”. Only one day later and the dressing will be filthy! What would he have done in just one day? Now could it be ... because sometimes I try to look at the other side ... could it be ... did anyone advise him not to do things that would get it dirty? (Tony)

Contrarily, during an informal conversation, a nurse said that she could not think of any instances where she had witnessed asylum seekers being treated differently but despite this, she reported sensing a certain negative vibe during cross-cultural encounters. This nurse believed that the negative vibes arose from the stereotypical image HCPs’ held of asylum seekers as uneducated and as having low, or non-existent health literacy. Indeed, various instances of ‘Othering’, with resultant discriminatory practices amongst HCPs, was clearly demonstrated in the previous chapter.

Nevertheless, as mentioned previously, the asylum seekers’ testimonies of their experiences of discrimination when accessing primary healthcare services varied considerably. These ranged from assertions that they had never encountered any discrimination: *”I haven’t experienced treatment which appeared to be different to the other Maltese patients”* (Amiir), to reports of having been exposed to instances of discrimination: *“It depends on which doctor, or nurse you get. Most treat you equally but there will always be one, or two who do not”* (AS, IC), to a minimal number of asylum seekers who recounted a narrative that depicted a continuous cycle of discrimination: *“Most of the carers they discriminate just because we are African”* (Baba). According to Jamaal, it is inevitable that different people have different experiences: *“you know everyone has different experiences ... it depends on the person needing the treatment and it depends on the person providing the treatment”* and this was clearly evident during observation. There are at least two other plausible explanations that could have had an additional impact on this extreme variation. Firstly, there could have been a measure of social desirability bias on the part of the asylum seekers, which was possibly compounded by my being required to wear a lab coat during observation. Secondly, the immensely diverse backgrounds and past experiences of the asylum seekers’ would have inevitably

resulted in varied expectations, which in turn would influence their perceptions of the quality of care they received.

Ndidi was one of the asylum seekers who reported that she repeatedly encountered discrimination when accessing healthcare and asserted that this was the product of a racist workforce: *“The healthcare system is very good but it is not good for me personally because wherever I go the nurses and doctors see me as the other and treat me differently ... they are racist. Because of this my experiences are bad.”* During observation I was never witness to any healthcare professionals exhibiting overtly racist behaviour but there is sufficient anecdotal evidence for one to presume that there are instances when this does occur. In fact, in addition to some of the asylum seekers’ testimonies of racist behaviour and as already touched upon, a number of HCPs recounted situations where they had witnessed a co-worker acting in a racist manner:

Sometimes you find staff not treating asylum seekers as they should and I do not agree with this because once they are here, you need to treat them as you would the other patients ... but because you have more than one person, you have different opinions ... when I see this, I try not to go along with that person, to show that I don’t approve ... I think that is the most that one can do (Miriam)

Whilst racist behaviour did not appear to be widespread and was limited to a small number of healthcare professionals, it would have a significant impact on the affected asylum seeker. As this nurse explained:

Sometimes you’re going through the files of the patients who come for nebulizers and dressings and you see a name and wonder what happened to that patient and then you see the last entry and who had cared for that patient and without wanting to ... you plus one with one and you say to yourself, “this patient won’t be coming back” (Maria)

Healthcare professionals are a reflection of society at large, so whilst there only appeared to be a small number who expressed overtly racist views, there were a substantial number

who demonstrated a xenophobic attitude: *“I was outside on visits and a colleague rang me and told me, “listen, there is this home visit, these two blacks came” ... when I heard that, my heart already missed a beat”* (Anna) and ethnocentric tendencies: *“these people have only a minimal idea, or understanding of civilization as we know it”* (Nurse, IC). Possibly because of widespread notions of ‘Western superiority’, these sentiments are so commonplace within Maltese society that comments such as these were stated as fact and there seemed to be a lack of awareness amongst these HCPs that these attitudes were in any way bigoted. Furthermore and as previously stated, there also seemed to be no realization of the negative effect that such an outlook could have on the quality of their relationship with these patients, or care provision generally.

Another area that suggested an ethnocentric approach was HCPs’ perceptions of the submissive stance that the asylum seeker women would take when on a medical visit accompanied by their husbands and their responses to this. A number of the HCPs’ recounted how in these situations, they would insistently address the woman. As Carmen explains:

It gets me so angry, I want to shake her and say come on ... tell him to shut up and tell me what you really feel and want! But obviously I don’t. So instead, I just speak to her directly and ignore her husband ... or whatever he is, even though he is doing all the talking and deciding (Carmen)

Whilst the HCPs who take this approach do so in belief that they are being supportive of the women, an asylum seeker whom I met during observation, referred to this practice as cultural insensitivity:

Sometimes, the doctors and nurses look at me in a certain way ... like they pity me. This is the way that I have always lived my life. First my father and now my husband. But no ... in their eyes this is bad and although I know that the way they act is for my good ... in reality, it harms me. (AS, IC)

The absence of a migrant health policy was another factor that potentially had a negative impact on the asylum seekers' health outcomes. An official who worked with asylum seekers spoke to me about the instability of a system "*that accommodates, without giving a right*", further fuelling a sense of insecurity. This lack of clarity amongst HCPs regarding what asylum seekers were entitled to emerged frequently, both in interviews and observation, when doctors and nurses gave multiple, divergent and incorrect versions of entitlements and how these could be accessed.

As is evident from the above, asylum seeker healthcare utilisation and provision is an intricate maze that is shaped and reshaped by a myriad of factors, including the preconceived notions and expectations of the key players. The associated difficulties appear to be magnified within an institution that is not fully cognisant of the necessary resources and support to satisfactorily address either the asylum seekers' healthcare needs, or HCPs' effective response to these needs:

As an institution we make things slightly difficult for them ... we don't have the appropriate supporting services. We don't even know what they need in specific circumstances ... let us say a black person is dying, do we know who we should call? We ourselves also do not have enough knowledge. How can we offer a service if we don't even really know their culture and their needs? (Carmen)

Needing Support

A substantial number of healthcare professionals expressed a desire to be better equipped with the knowledge that would enable effective care provision to asylum seekers. Despite this, many of the healthcare professionals that I spoke to had never received any training with regard to caring for patients from diverse populations:

I have never gone to any lectures about them. It would be nice to have a course, which could help us, even on how we should approach them and how to get along with them ... I feel also their culture because once you know their culture you could

say “oh at this time, this is why they are like this” ... Lets say during their Ramadan ... that thing you have to wake up fasting ... I could never do that (Maria)

As mentioned in Chapter five, a significant number of HCPs also felt that having more knowledge about the culture of asylum seekers would help reduce their feelings of incompetence. These sentiments served to reveal yet another measure of ambivalence, whereby previous assertions of different characteristics amongst the different nationalities appeared to be forgotten and the asylum seekers were now being accorded one culture. The following doctor spoke about how he had initially addressed his own feelings of incompetence by supplying himself with the necessary information:

Way back there would have been a certain sense of being inept ... how to deal with this and find out what is really going on with the patient and all this stuff ... erm ... I had a total vacuum of knowledge about them. So to make me feel better I did some research ... not only on medicine particular to Africans and all this stuff but I read up a little on their culture as well. That is how in my small way I tried to patch things and now to tell you the truth, my anxiety is pretty low (Tony)

This doctor additionally mentioned the importance of having some ‘*protected time*’ during their hours of work, which would enable the necessary research to be carried out. Tony further mentioned the benefits of having some form of helpline that could be contacted whenever required. One of the nurses also bemoaned the lack of a helpline and further criticised what she considered to be a lack of adequate institutional resources and support. This latter complaint was voiced by a number of other healthcare professionals and their sentiments are aptly represented in this citation: “*We don’t really have the required resources ... it’s as though as long as things move along and there aren’t any reports ... then irrespective of the care we give, all is okay!*” (Doctor, IC). Another of the nurses felt that the healthcare professionals did have the required knowledge but were hindered by too much bureaucracy and time pressures. As mentioned previously, excessive demands on time was particularly evident in one of the Health Centres where I carried out my observation, which would be packed with asylum seekers mainly waiting to see the GP, in the late morning and early afternoon. In fact, during my observation, one of the doctors

was speaking about the benefits of carrying out a study exploring asylum seekers' helpseeking behaviours, which would possibly provide the information for better planning to take place. Incidentally, at the time of this present study the sole documentation being recorded at the Health Centres were the names and identification numbers of the patients who attended the various clinics.

A number of the healthcare professionals appeared to become frustrated when they felt that they were not providing asylum seekers with the optimum care and the above-mentioned propositions were mooted by them as strategies that would enable them to provide a better service. It seemed important for these healthcare professionals to have some confirmation that they were doing a good job and in so doing, validate their role as caregivers: *"I feel proud when they ask for me specifically ... let's say I would have done their dressing and the day after they wait for you to come from your break so you would do it again for them ... it's an honour"* (Carmen).

In addition to institutional resources, educating the migrants themselves in relation to health literacy was also mentioned as a strategy that would improve care provision:

If only some one could educate them on how to use the services appropriately. Last time a man came with his son and I saw him, even though he came to the wrong Health Centre. Then he asked "if he gets fever at night, what do I do?" I said, "give him this medicine". Then he said "but if it doesn't go down, shall I take him to emergency? Shall I phone emergency?" So then I explained the procedure of going to the correct Health Centre to be seen by a GP etc... I suppose everyone needs that bit of guidance. (Doctor, IC)

When talking about appropriate use of services a number of healthcare professionals also referred to teaching asylum seekers about appropriate forms of behaviour when accessing services. This behaviour they spoke about was often related to entering a clinic without knocking: *"You know, they just open the door of the treatment room and come in, or perhaps they peep round the curtain ... we need to educate them for things like this"* (Nurse, IC). Despite two or three HCPs mentioning this, I never witnessed this behaviour

myself during my observation in the treatment room, or any other clinics and suggest that this could be another instance where the behaviour of a few becomes representative of all asylum seekers. Another healthcare professional used a situation like this to justify incorrect behaviour by a nurse placing the blame on the asylum seekers for instigating these types of responses:

So he would say things like “go and stay there, you are less than me! Sit down and wait there for me and do not come in until I tell you to!” ... I’ve seen this ... but some of them just make you lose it ... really. You would have had one of those days and he comes and opens the door and just comes in on another patient ... don’t you know? (Anna)

During my observation it was clear that what asylum seekers did require was more support on how to navigate between the various healthcare services, which varied in complexity according to the situation. On one of the occasions the doctor spent quite some time explaining to a patient from Ghana how he was to go to another location to have an X-Ray taken and then how he was to make an appointment to get the result. Although there was no marked language discordance, by the end of the encounter it still was not a certainty that the instructions had been fully understood.

Education for asylum seekers on healthy behaviours was an area that all the HCPs highlighted as essential and this topic took quite a patronising turn as the issue was mostly discussed in terms of their personal hygiene, which the doctors and nurses claimed was generally lacking:

With regards to hygiene that’s one of the things ... now it could be that their skin, in a way, however much they wash there would be a certain smell ... something that is natural in them I mean. But I think that they don’t wash and that is what I think ... and also perhaps, they don’t change their clothes ... that’s another thing (Mark)

Irrespective of the above and similar citations, there were some healthcare professionals who took the asylum seekers’ living conditions into consideration: “*I think that where they*

would be living could have a strong bearing on their hygiene” (Maria). Nonetheless, irrespective of what the HCPs presumed to be the cause of this lack of hygiene, cleanliness is a big issue for healthcare professionals, especially nurses and their notion of asylum seekers being unhygienic served to imbue the ‘Others’ with additional undesirable characteristics.

Summary

The above findings provide narratives of the asylum seekers’ healthcare journey and address issues such as their learning about the services, accessing these services in a correct manner, achieving mutual understanding in healthcare encounters and reaching resolution of the presenting problem. These narratives clearly depict some of the challenges that asylum seekers face in every phase of this journey and that culminate in medical encounters. The findings further show the difficulties that both the asylum seekers and the HCPs face, when they engage in these encounters that are so often typified by discordant expectations of how resolution is to be achieved, prejudiced perceptions and behaviours.

All of the findings appear to place an emphasis on the strong impact that experiences, events, structural forces and structural policies have on the behaviours of both asylum seekers and HCPs, as they grapple, often unsuccessfully, to achieve mutual understanding and a satisfactory resolution of the presenting problem in their medical encounters. The following chapter will discuss these findings through a conceptual framework that enables a close examination of healthcare encounters through the various influential elements that help shape these, with the additional inclusion of critical theories that acknowledge the heterogeneity of the participants and help identify postcolonial consequences.

Chapter 7: Healthcare Encounters – A Chaotic Bricolage

Introduction

Healthcare encounters are the locus through which healthcare provision and utilisation are actuated and the present study aimed to explore healthcare encounters amongst asylum seekers, healthcare professionals and health services in the primary healthcare setting through observation and interviews. This chapter will present a discussion of the findings as presented in Chapters Four, Five and Six, where, despite the common aim of achieving mutual understanding and a resolution to the presenting problem, healthcare encounters at the micro level can best be described as a chaotic bricolage. This is so because of the various, sometimes conflicting, influences that arise from a medley of dominant discourses at the macro level and social structures at the meso level. A new framework has been developed to aid understanding of these healthcare encounters (see figures 2, 3, 4 & 5), derived from a conceptualization of candidacy in access to healthcare (Dixon-Woods et al, 2005; Mackenzie, Conway, Hastings, Munro & O'Donnell, 2013) and through an analysis shaped by a postcolonial perspective, further informed by the theory of intersectionality. In the same way as the findings, the analysis has drawn on all the different forms of data sets simultaneously.

This chapter will begin by outlining the candidacy approach and the rationale behind the utilisation of Mackenzie et al's (2013) adapted version of candidacy. Following this an overview of intersectionality theory will be offered, with further reference to the rationale underlying the utilisation of this theory in combination with a postcolonial perspective. The discussion of the findings will then be considered through the seven dimensions of candidacy, namely: identification of candidacy; navigation; permeability of services; appearances at health services; adjudications; offers and resistance and operating conditions and local production. Finally, an illustration and description of the new framework that represents the recursive cascades of influence will be presented. This framework is the outcome of the analysis of the findings of the present study which as the ensuing discussion will show, highlights the interdependence of a variety of discourses and structures on healthcare encounters and vice versa.

The multilevel framework made up of micro, meso and macro levels (Figure 1) utilised in sociological enquiry represents different elements of the social world, with the micro focusing on the personal processes and interactions, the meso focusing on social structures and locations and the macro level focusing on the large-scale national structures and the global community (Johnson, 2008). A range of factors at the micro, meso and macro levels determine the nature of a healthcare experience and it is therefore essential that inquiries into the utilisation, provision and receipt of healthcare, employ a theoretical framework that enables these influential factors to be taken into full account. Candidacy is a theoretical concept that emerged from the findings of a critical interpretive synthesis, which examined healthcare access to vulnerable groups (Dixon-Woods et al, 2005; 2006) and has since been advocated as a valuable tool to investigate the healthcare process at individual, social and structural levels (Koehn, 2009; Mackenzie et al, 2013; Methley, Campbell, Cheragi-Sohi, & Chew-Graham, 2015). Moreover, Dixon-Woods et al (2005) highlighted the benefits of utilising a combination of both interview and observational data when examining healthcare pathways through the concept of candidacy, claiming that the exposure to the clinical encounters would promote a deeper understanding of the relevant dimensions. It is in consideration of this that the discussion of the findings will be presented through the synthetic construct of candidacy.

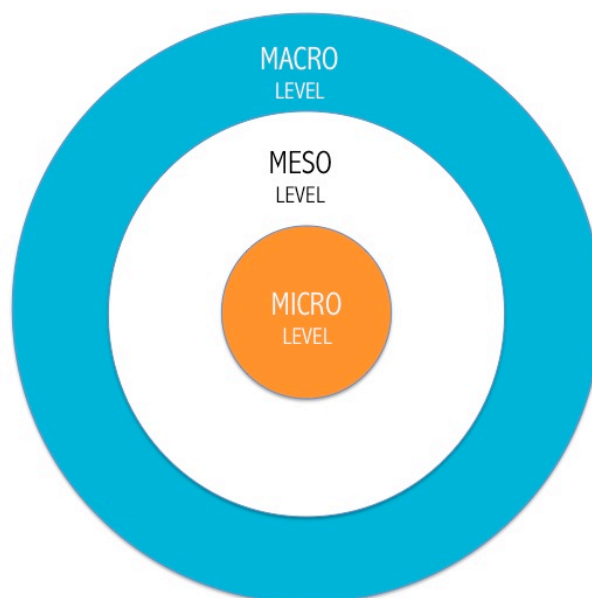


Figure 1: Multilevel Framework

The Candidacy Framework

The concept of candidacy was conceived by Dixon-Woods et al (2005) and is based on the premise that a person's eligibility for healthcare is socially constructed and is established through the complex interactions between patients, healthcare professionals and healthcare services, within a specific social, organisational and political context. This premise enables a holistic inquiry into healthcare utilization, provision and receipt, which is further facilitated by the identification of the above-mentioned seven interrelated dimensions within the candidacy framework that represent the whole healthcare pathway (Dixon-Woods et al, 2006). Through these dimensions, the candidacy framework moves beyond models that were generally utilised previously with their sole focus on supply and demand and presents a model that is in full recognition of how social determinants of health have an impact on the interactive processes at every stage of the healthcare pathway and ultimately, on an individual's health status. This is achieved through a broad understanding of access as "highly dynamic, multi-dimensional and contingent" and therefore, unlike past frameworks, goes far beyond a sole focus on healthcare service availability and utilisation (Dixon-Woods et al, 2005, p272) and helps address influential structural, psychological and sociological factors equally (Methley et al, 2015). Additionally, the candidacy framework gives consideration to the attitudes and expectations of all the stakeholders, thereby including both the patients and the HCPs, which is highly relevant in view of the potential negative impact that various forms of racism, on both an individual and societal level, have on asylum seeker access (Williams & Mohammed, 2013).

The Commission on the Social Determinants of Health (CSDH) established by the World Health Organisation in 2005, identified social determinants as arising from both material and structural explanations (Marmot et al, 2008) and this was further corroborated by findings from a study by Ahnquist, Wamala & Lindstrom (2012) that showed economic and social capital as major determinants of health. Migration has also been recognised as a major social determinant of health (Davies, Basten & Frattini, 2010; Karl-Trummer & Sardadvar, 2012). Gushulak & MacPherson (2010) have argued that this is due to the poor living conditions and social marginalisation that migrants often experience on their arrival in the host country, with irregular migrants and refugees being specifically identified as at

a higher risk for adverse health outcomes. Similarly, Rechel et al (2011) identified asylum seekers and undocumented migrants, as well as trafficked persons, as the cohorts of migrants who are most likely to face the greatest challenges in terms of material and structural barriers to healthcare access. This further highlights the benefits of utilising the candidacy framework that brings these multi-dimensional processes to the fore, including their impact on all the stakeholders throughout the healthcare journey and in so doing, enables a more holistic understanding of the processes involved.

Whilst Dixon-Woods et al (2005, 2006), claimed that their concept of candidacy encourages an examination of influential factors at various levels, Mackenzie et al (2013) concluded that the cyclical nature of this process should be further highlighted and these latter authors developed an expanded model of the candidacy framework that emphasises the dependence of micro-level interactions on “mutually reinforcing contextual meso and macro layers” (p 820). Mackenzie et al argued that in certain circumstances, an investigation into access, provision and receipt of public services requires an exploration of how interactions and social structures impact on political and public discourse and policy at the macro-level and how this level reciprocally engages with the meso and micro-levels of the social world to determine candidacy. Mackenzie et al’s revised framework is highly relevant to this present study because of the negative discourses that surround asylum seekers, which reverberate synergistically between the micro and macro levels. Indeed, following the influx of over 800,000 asylum seekers to Europe until November 2015 (Human Rights Watch, 2016), the current political climate in the majority of European countries is one that views this influx as an ‘invasion’, giving rise to a generally negative political and public discourse of forced migration as an insurmountable economic burden, as well as a threat to collective national identity and national security (Bourbeau, 2015). The situation in Malta is no exception and Malta’s suspension of the Schengen agreement that was originally implemented for the month of November 2015, was extended to the beginning of the New Year following the terrorist attacks in Paris (Dalli, 2015).

It is in view of the above that Dixon-Wood et al’s (2006) seven dimensions of the candidacy framework have been utilised to present the discussion of the findings of this present study as presented in Chapters Four, Five and Six, with an additional unique focus

on the inter-relatedness of the macro, meso and micro influences, as advocated by Mackenzie et al (2013). However, it is also important to use a research paradigm that recognises and enables an analysis of the diversity represented by the category 'asylum seeker'. Asylum seekers are not a homogenous group (Hynes, 2011) and they represent a range of ages, genders, past experiences and cultural backgrounds amongst other factors, all of which intersect and impact healthcare access and experiences and which therefore should be given due recognition. It is in acknowledgment of this that this thesis has combined the use of a candidacy framework with a theorisation of intersectionality.

Intersectionality

The concept of intersectionality was conceived by black feminists in recognition of women's diverse lived experiences and is based on the premise that individuals are differentially situated, depending on the social categories they belong to at that moment in time (Lutz, Herrera Vivar & Supik, 2011), which are shaped by structural factors (Vakulenko, 2007). Similarly, people experience healthcare services and policy in different ways to each other, depending on the intersectionality of the varied multiple social forces. Intersectionality has been touted as a highly beneficial approach to examine health inequities at all levels. This is because of its ability to focus attention on the impact that the intersection of social differences and markers of oppression within each specific context have on health care access, provision and utilisation (Dhamoon & Hankivsky, 2011). It is in acknowledgement of this theory's potential to enable an interpretation that looks beyond essentialist discourses of identity that intersectionality theory will be drawn upon, whenever deemed relevant, to discuss the findings of this present study.

Notwithstanding this, whilst an intersectional approach highlights asymmetrical power relations and differential experiences depending on one's positionality (Schurr & Segebart, 2012), Salem (2014) argued that combining this approach with a postcolonial perspective, which has been described in Chapter Three, will further guide the enquiry towards an understanding of how assumptions about the 'Other' arise from 'Westernised' ways of knowing that in turn determine the multiple oppressions that ultimately dictate positionality. The suitability of this stance is corroborated by Wallaschek (2015), who

highlighted the connectedness between intersectionality and postcolonial theory and further claimed “that a closer dialogue between both theoretical perspectives can sharpen the view on multiple discrimination and injustice in times of neoliberal capitalist hegemony” (p 218). To my knowledge, this is the first study wherein intersectionality will be utilised in conjunction with a candidacy framework and a postcolonial stance, thereby providing an original contribution.

This combination has resulted in the development of a conceptual framework that has emerged from the data and which is representative of the multiple dimensions that are incorporated in the dominant discourses at the macro level and the social structures at the meso level. These two levels interact with each other, as well as with the micro level in a symbiotic and recursive fashion, to shape healthcare encounters through the influential elements that are a product of the discourses and structures and that serve to reproduce power imbalances and inequities.

Identification of Candidacy

The motivation for an individual to seek medical help arises from an understanding that one’s own recognition of need is well founded, legitimising a claim to candidacy. Dixon-Wood et al’s (2005) report shows the complexity of this dimension in minority ethnic groups, not least in the extreme diversity to be found within groups, despite the categories and radicalised stereotypes that people are generally boxed into. The discussion which follows will show how the epistemic violence that arises out of dominant postcolonial discourses and which produce binaries such as ‘Us’ and the ‘Other’, impacts not only on an asylum seeker’s identification of candidacy but also prompts diagnoses of previously unknown ‘Western illnesses’ and promotes the sole utilisation of a biomedical approach to care. Additionally, the discussion will show how discourses that culminate in the stigmatisation of asylum seekers, result in delayed presentations, as individual asylum seekers attempt to neutralise these stereotypical assumptions.

As can be seen from the findings of the present study, the majority of asylum seekers identified themselves as eligible for candidacy when symptoms started to impact negatively on their ability to carry out activities of daily living, or on their occupational duties. Similarly, most of the HCPs reported that it would be more likely that asylum seekers would present later in the illness, rather than earlier. The reasons for this delay could be related to issues linked to either the identification of a health need, or to acting upon that need.

In this study, four out of the six asylum seekers with a mental health disorder were diagnosed following an emergency admission to the psychiatric hospital because of a psychotic crisis. This could possibly indicate that the symptoms leading to these psychotic episodes were not acknowledged in line with Dixon- Wood et al's (2005) assertions that there are some "Western illnesses" that are not universal and in these situations, despite being afflicted, a person might not have any cognition of being legitimately ill. The findings in Chapter Four report that Patrick was living in the community when he was picked up by the police and taken to the psychiatric hospital. Patrick explains that the police mistakenly thought that he was mentally ill, solely as a result of the environment that he was living in. Irrespective of Patrick's assertions, once seen by a psychiatrist he was admitted to the psychiatric hospital for treatment.

Knowledge has been identified as an enabling factor to healthcare access (Boateng et al, 2012) and the asylum seekers' lack of acknowledgement that varying degrees of mental status are an indication of mental illness as cited above, could have been the cause of the delayed presentations. None of these six participants could specifically name their psychiatric disorder, so much so that when I asked them why they had been admitted to the psychiatric hospital, all of them (apart from Patrick referred to above), reported that they did not know and when prompted further said that it was that they were "*thinking too much*". This possibly corroborates Miller's (2013) claims that there are a variety of areas globally where parallel concepts of Westernised notions of mental illness do not exist. The implications of this could have far-reaching consequences, in view of the comparatively

high diagnostic incidence of mental illness in refugees and even more so, in asylum seekers (Robjant, Hassan & Katona, 2009). A study on the incidence of psychosis carried out in Malta by Camilleri, Grech & Taylor-East (2010) showed a similar trend, with a considerably higher incidence of 'irregular' migrants requiring hospitalisation for psychosis when compared to the host population.

Findings from a meta-analysis of studies carried out with displaced persons and refugees worldwide attributed this raised incidence of mental disorders amongst the sample population, to a variety of pre- and post-migration factors (Porter & Haslam, 2005). Whilst Mann & Fazil (2006) discussed the possible impact of these multiple factors on asylum seekers' and refugees' mental status, they also questioned the wisdom of utilising assessment tools developed for a different population and highlighted how this practice had the potential to result in diagnostic errors. These authors stated that perceptions and understandings of mental illness differ among diverse cultures, as do responses to traumatic experiences and attested that an assessment of mental status should only be made in full cognition of the relevant system of knowledge and of the social context. The history of cultural psychiatry shows a generally persistent and sole reliance on Western knowledge as the ultimate truth (Kirmayer, 2007), which from a postcolonial perspective is the product of a colonialist past and is utilised as a means of maintaining positions of privilege and power (McLeod, 2010).

Spivak (2010) referred to this practice as epistemic violence and she further charted the process of the creation of binaries such as 'Us' and the 'Other' and the total lack of any cognisance of the 'Other's' episteme. This form of oppression is a consequence of belonging to a specific group (Dotson, 2011) and Tuana (2006) has argued that the criteria utilised to establish "cognitive authority" (p 13), is replete with prejudicial biases including racism amongst many others. Within healthcare, this ethnocentric approach has resulted in biomedicine being viewed as a system of healthcare provision far superior to any other (MacFarlane & de Brun, 2010). Furthermore, the lack of epistemological pluralism could lead to alternative reactions to stress becoming pathologised, resulting in additional stigma and marginalisation of the afflicted asylum seekers (Mann & Fazil, 2006) and who, like the

asylum seekers in this present study, have been diagnosed with a mental illness that they could not name and the symptoms of which they could not identify.

Shame, Stigmatisation & Identity

Mental illness is not the only illness that is socially constructed and there are other instances in the findings of this present study where an individual's explanation of a specific symptom or illness would impact their identification of candidacy in terms of eligibility and deservedness, as a result of feelings of shame and fear of stigmatisation. So much so, that the asylum seekers whom I encountered with either an unwanted pregnancy, or a suspicion of a sexually transmitted disease, all delayed their presentation at the clinic. For example, in Chapter Six there is a description of a doctor's narrative of a male asylum seeker who attended the walk-in clinic with a venereal disease at an advanced stage because he had been too ashamed to visit the doctor earlier and further believed that this was a deserved form of punishment from "Allah". Comparably, a study carried out in the USA with African born immigrants and refugees who had tested positive for the human immunodeficiency virus (HIV), highlighted how helpseeking behaviours were affected because of the stigma and shame attached to this illness amongst the African community, with some of these believing that this was a punishment from a divine being (Othieno, 2007). Additionally, HIV positive refugees and asylum seekers also face stigmatisation from the host population (Cherfas, 2006), who as evidenced by the testimonies of the HCPs participating in this present study, already hold a general view of refugees and asylum seekers as harbingers of pestilence and disease. This stigmatisation was clearly demonstrated by the HCPs' descriptions of how they would automatically take extra precautions when caring for a 'black' patient, as is discussed further on.

Goffman (1963) defined stigma as the possession of an "attribute" (p 12), which is viewed as objectionable by the dominant discourses at all levels, resulting in marginalisation. Moreover, Flowers et al (2006) maintained that there is a link between the stigma that arises out of a diagnosis of a sexually transmitted disease and one's identity. Identity is a multiple concept in a constant state of flux, as it is moulded and remoulded through interactions with others within current discourses that yet again serve to create a distinction

between 'Us' and 'the Other', through the process of inclusion and exclusion (Hall, 2000). Hall contended that self-identity is mainly formed in recognition of social perceptions and therefore, the 'labeling' of asylum seekers, especially when this 'labeling' has emerged from a colonialist perspective, serves to exacerbate notions of 'Us' and 'Them' with asylum seekers progressively perceiving themselves as 'Other' (Zetter, 2007). Migration to a new culture is within itself a threat to an individual's identity (Hopkins, 2010) and this threat is amplified in asylum seekers who are ascribed with characteristics perceived as negative and who are socially excluded, solely by the virtue of their title (Goodman & Speers, 2007).

Chapter Six shows how Maryan delayed attending antenatal visits until she could not hide her pregnancy any longer. In their review, Dixon-Woods et al (2005) cited studies that showed the impact that identity has on ethnic minorities' identification of candidacy and reported how these groups would delay seeking care for illnesses which they believed could result in blame and shame and which would further threaten their individual identity. This appeared to be the situation with Maryan, who felt both ashamed, as well as worried, about being stigmatised because of the circumstances of her pregnancy. Indeed, when she did talk about it, her sister was the only person with whom she shared the lurid details of the conception. Possibly as a result of this non-disclosure, as well as the fact that neither Maryan nor her sister could speak any English or Maltese and interpretation services were not available during her labour, Maryan was never offered any psychological support. The reluctance of refugee women to share these traumatic experiences appears to be a common occurrence (Gerard, 2014), as does the resultant disadvantage of not having access to the psychological support that they might need (Gangsei & Deutsch, 2007).

It is not solely a perceived threat to individual identity that could deter, or delay, an individual from seeking medical help but also a perceived threat to the identity of their community (Dixon-Woods et al, 2005). Host societies tend to view asylum seekers as riddled with HIV and other diseases (Cherfas, 2006) and as shown in Chapter Six and further discussed below, these views are also held by the majority of the HCPs in the PHC sector in Malta. Cherfas further contended that because of this asylum seekers might try to avoid providing the fodder that would validate these negative views of the communities

that they represent. In Chapter Four of the findings, Baba provides a description of the reception that he and the other asylum seekers got when they were brought to Malta on an Armed Forces patrol boat, following a successful rescue operation at sea. In his narration, Baba does not only question the necessity of the protective clothing and masks worn by the rescuers but further concluded that this attire was an indication of the local population's perception of asylum seekers as disease-ridden.

An acknowledgement of these negative perceptions could be one of the reasons for delayed presentations described in this study, with the asylum seekers loath to provide any substantiation of HCPs' beliefs that asylum seekers suffer from a high incidence of communicable diseases including sexually transmitted diseases. These beliefs are not solely held by HCPs but have also been found to resonate throughout a large proportion of the Maltese population (Amnesty International, 2010). Flint and Hewitt (2015) chart the discourses surrounding the HIV/AIDS pandemic in Africa and show the similarity between past and present colonial discourses that has resulted in "a largely unbroken outsider view of sex and disease associated ultimately with the colonial European construction of African bodies and desires" (p 294). This provides another instance where the impact of past colonial discourses is made visible through their influential role in cross-cultural interactions.

The repercussions that colonial discourses at the macro-level have on clinical interactions at the micro-level, is evidenced by some of the HCPs who participated in the present study and who professed to discriminatory practice with asylum seekers, or more precisely 'black' patients. The HCPs described instances of how they would take more precautions with their 'black' patients because of their perceived higher risk of contracting HIV, or some other transmissible disease. This is evident in Chapter Six where a nurse (Mark) recounts the extra precautions that he and his colleagues take when drawing blood from a 'black' person. Various international studies have attested to the existence of racial discrimination in healthcare (Williams et al, 2012) and Browne et al (2011) described how racialisation and marginalisation experiences on a regular basis increase ones anticipation of, and sensitivity towards, discriminatory practice, which in turn affects helpseeking behaviours. In addition to delayed presentations, perceived discrimination in ethnic

minorities also has deleterious effects on re-attendance and self-reported health status (Lee, Ayers & Kronenfeld, 2009). This idea will be expanded upon and discussed further below.

Whilst the above discussion provides instances wherein asylum seekers' personal and group identities are in concordance, certain HCPs' practices such as the one described by Simret below, can result in a dissonance between asylum seekers' perceptions of their own personal and group self identity (Rainbird, 2012). In Chapter Five, Simret describes situations where some doctors attempted to prevent him from obtaining free medication to which asylum seekers are entitled. Simret further provides his interpretation of the doctors' behaviours, saying that this is possibly a reaction to medication non-compliance by the asylum seekers' resulting in a waste of resources, or because of the burden that such a large number of asylum seekers have placed on a small country. In a part of this narration, Simret appeared to be distancing himself from certain asylum seeker characteristics that he deems undesirable and which he believes, has a negative impact on the way that the doctors treat him, further threatening his eligibility for healthcare. Contrarily, in the part of his narration where he spoke about the burden that asylum seekers pose, Simret appears to be assuming an asylum seeker identity and Goffman (1963) refers to this form of ambivalence as "inevitable" (p 130) in a stigmatised individual, who can "neither embrace his group nor let it go" (p 132). Forced migration and the resultant asylum seeker 'label' has an impact on an individual's sense of identity (Douglas, 2010) and Piacentini (2008) further highlighted how asylum seekers' identities are formulated within "a liminal space of neither here nor there" (p 2), through a potentially conflicting dialectical interaction between individual and collective identities. The resultant "fluid identity" impacts on the individual's sense of self (Rainbird, 2012, p 140) and affects their own and other people's notions of their eligibility.

A Biomedical Approach to Care & Transnational Conversations

The confidence that one has in one's own health literacy has been cited as another factor that influences identification of candidacy (Dixon-Woods et al, 2005) and Scheppers, van Dongen, Dekker, Geertzen & Dekker (2006) identified various situations that people from

ethnic minorities experience, which could negatively impact on their confidence. Additionally, as mentioned above, asylum seekers tend to avoid situations which they believe could threaten their self-identity and this threat would include the disapproval of healthcare professionals for what they consider to be an inappropriate medical visit (Hopkins, 2010). To avoid this, people from ethnic minorities would often seek advice about symptoms from others, often from family and friends in the migrant's country of origin (Messias, 2002). Amiir, an asylum seeker whom I interviewed, rang up his uncle in Somalia to discuss his symptoms, which led him to suspect that he had tuberculosis and which was then diagnosed when he visited the doctor. Patrick, another asylum seeker, would also call his mother, who was a nurse in their home country of Sierra Leone, for medical advice. Indeed, Patrick had refused to undergo a bilateral hip replacement in adherence to his mother's counsel, despite this operation being advised by orthopaedic surgeons in both Denmark and Malta.

Asylum seekers sustain different types of connections with their countries of origin (Levitt & Jaworsky, 2007) and depending on the situation in the host country, these transnational links could influence diverse aspects of healthcare access (Wang & Kwak, 2015). As can be seen in Chapter Five, Meraf a cultural mediator, intimated that if asylum seekers become mistrustful of the healthcare system, some of them would resort to practising traditional medicine. Iman, another cultural mediator, held slightly divergent views and reported that while some asylum seekers preferred treating their symptoms with certain herbs, they were unable to do so locally because these herbs were unavailable in Malta. Findings from a study carried out amongst Southern African migrants in London, identified factors, apart from eligibility for healthcare, which underlie the participants' motivation to engage in some form of transnational health behaviours. The factors included a belief that their general practitioner would not be able to satisfy their medical needs with regard to some specific symptoms, as well as a perception that doctors tend to minimize problems (Thomas, 2010). O'Donnell et al (2008) have argued that an asylum seeker's lack of confidence in the general practitioners of their host country, is generally based on the belief that 'Western' doctors would not be able to understand some of the illnesses that assail them because of their sole reliance on biomedicine, which runs counter to Africans' use of diverse medical approaches both in Africa (Carruth, 2014), as well as in their host

countries (Tiilikainen & Koehn, 2011). In this present study, Iman reported Somalis' expectations of a holistic approach to care, as opposed to the sole focus being placed on the affected body part, which Iman further asserted is generally the approach utilised by the doctors in the Maltese health centres. The findings in Chapter Five show further evidence of asylum seekers' expectations of holistic care when Simret, amongst others, talks about the importance of doctors taking "*time to understand*".

As shown in Chapter Five, the Maltese healthcare system generally utilises a biomedical model of care and results from a study that examined the conceptual frameworks guiding health education in 14 countries, showed that in this situation, Malta's use of a biomedical approach stood at 98.7% (Carvalho et al, 2007). Following an indepth study into the practice of health with Mexican migrants in the United States (USA), Holmes (2012) argued that biomedicine is a major obstruction to successful transcultural healthcare activities, in the way that it reduces illness to "biological and behavioural explanations" (p 880). As discussed in Chapter Two, a biomedical approach is a medical system that has dominated healthcare provision since the twentieth century (Wade & Halligan, 2004) and the benefits that are reaped from this approach are highly significant to this present day. Notwithstanding this, biomedicine's underlying explanations of health, illness, the body and 'truth' results in a failure to see the person as one whole being, with medicalisation resulting in a lack of consideration being given to socio-economic and broader factors and a refusal to acknowledge different explanations of health and illness (Willis & Elmer, 2011).

In Patrick's case, his refusal to have a hip replacement operation as described previously, was not due to discordance in illness explanations or healthcare systems. Patrick stated that his mother had told him that he was too young to have the operation and that this would result in him requiring another operation later in life because of the deterioration of the prosthetic parts. Despite this information being correct (National Institute of Arthritis and Musculoskeletal and Skin diseases, 2013), Patrick affirmed that the orthopaedic surgeons whom he had consulted had never discussed this eventuality, resulting in a reduction in his trust in them. The mistrust that arises out of a lack of information being given to the asylum seekers by HCPs was also raised by Meraf and a clear example of this is provided

by Caadil, who reported how he had initially refused to give his consent to a major operation because he was too afraid, having not been given any information by the medical team responsible for his care.

Dixon-Woods et al (2005) reported how experience and the resultant level of satisfaction with healthcare services, impact on how one responds to identification of candidacy and Abu, a cultural mediator from the present study, related how some of the asylum seekers would try to avoid further medical visits if their initial visit was deemed to be objectionable in any way. Abu further explained how other asylum seekers, especially those who had learnt the system, would ask which doctors were available and leave the clinic if the attending physician was one with whom they had previously experienced a bad encounter, to return on another day. Results from other studies have shown the impact that a HCP's interpersonal approach has on asylum seekers' notions of eligibility and willingness to utilise healthcare services (Asgary & Segar, 2011; Wahoush, 2009a) and upcoming sections will further show the influence that HCP approaches have on asylum seeker access throughout the healthcare pathway.

Identification of Candidacy: A Conceptual Overview

The above discussion clearly shows how the repercussions of a colonial discourse of 'Western supremacy' at the macro level infiltrate and influence structures and behaviours at both the meso and micro level and in turn, asylum seekers' identification of candidacy. This is demonstrated in a number of ways. Firstly, through examples of how notions of 'supremacy' result in epistemic violence, with the consequences of late presentations due to a lack of recognition of the symptoms, or to questionable diagnoses on the part of the HCPs. The impact of this epistemic violence is also evident in the exclusive biomedical approach to care and lack of pluralistic approaches that result in asylum seekers being dissatisfied and mistrustful of the care provision, with the potential that they might resort to transnational practices, as opposed to utilising local services. Secondly, the discussion illustrates how essentialist and stereotypical discourses around the label of "asylum seeker" also results in delayed presentation, as these individuals struggle to challenge these stereotypes, as well as find an acceptable level of equilibrium between their personal and

collective identities because of their “fluid identity”. Finally, the discussion addresses HCPs’ interpersonal strategies, which are shaped by dominant discourses on the macro level and structures on the meso level and which in turn influence transcultural healthcare encounters and asylum seekers’ future behaviours.

Navigation and Permeability of Services

Navigation follows identification of candidacy and refers to the paths taken to access health services. For navigation to be successful one requires knowledge of the services available and the ability to tap into the resources needed to satisfy any practical demands that enable access, such as transport and childcare (Dixon-Woods et al, 2005). Navigation of health services has been found to be challenging for migrants. So much so, that new and vulnerable migrants have been found to face difficulties, which are nearly as restrictive as those that arise from not having a medical insurance if required (Scheppers et al, 2006). Research on the resettlement of Somali migrants in New Zealand showed that it takes a substantial period of time for the majority of participants to navigate services independently (Elliot & Yusuf, 2014). The resources required for access is dependent on the permeability of the services, with services that have a high permeability requiring the mobilisation of fewer resources and less effort than services with a low permeability. In view of the close connection between these two dimensions, navigation and permeability of services will be presented in one section.

The following discussion will show how navigation and permeability of services by the participants of this study are impacted by various factors at the macro, meso and micro levels, which include marginalisation, discrimination, structural and “everyday” racism. Once again, these factors are greatly determined by the dominant discourses at the macro level, which impact the permeability of the social structures at the meso level in both a direct and indirect manner. Furthermore, the application of an intersectionality lens has highlighted how asylum seekers are placed in various hierarchical structures depending on their markers of difference and how this, in its turn, impacts their navigation of the primary healthcare services, as well as the permeability of these services.

As can be seen in Chapter Six, a large number of the asylum seekers whom I interviewed and encountered during observation, generally learnt about the required services from either family members, or friends who themselves were asylum seekers, or from other asylum seekers living in the residential centres. Those who were getting some form of support from non-governmental organisations, or lived in Open Centres, further reported that the staff employed by these organisations also supplied valuable information. In these last instances, the information would not be solely related to details about the services but also included additional medical information to supplement that which was provided during the clinical encounters. A situation such as this was evident in Caadil's narrative referred to previously, when he only agreed to undergo a major operation following extra information being provided by the staff at the Open Centre he was living in at that time.

Similarly, family and friends, neighbourhood networks and non-governmental organisations have been included as commonly cited providers of navigational assistance in the findings of a study carried out by Green, Davison, Bradby, Krause, Mejias & Alex (2014) that aimed to examine the navigational practices of migrants in four European countries. This study showed how the demand for navigational assistance is dependent on the interplay of a variety of factors, including social capital (Green et al). Social capital has been defined as a resource that develops out of social relationships and to which a value is assigned that determines whether one gains entry to a 'field', or not (Bourdieu, 1986). Rocco & Suhrcke (2012) reported the benefits of social capital on health, with "improved access to health relevant information" (p 3), being one of the positive outcomes cited. Despite these benefits, the processes associated with social capital can result in exclusionary practices (Portes, 1998) and Bourdieu (1986) asserted that social capital is a tool which is utilised by the dominant forces to preserve existent power differentials through exclusive social connections and in so doing reproduces inequalities.

Putnam (2000) claimed that the social connections related to social capital have two different patterns which he named bonding social capital and bridging social capital. Bonding capital refers to the strong relationships that develop amongst people who share a

common identity, such as family and ethnicity (Ager & Strang, 2008) and this capital provides social support and a sense of wellbeing (Calhoun, 2010). Calhoun further explained that bridging capital refers to the resources that arise from relationships that are formed with diverse populations and is the capital that provides opportunities for occupational and financial advancement. Several studies have repeatedly shown the lack of upward mobility in large indigenous communities with minimal connections to people from other communities (Almedom, 2005). Bonding has been cited as the form of social capital that is most commonly found amongst refugee communities (Marlowe, Bartley & Hibtit, 2014) and this was further confirmed by findings from a study which examined the integration of Somali refugees in New Zealand, through the concept of social capital (Elliot & Yusuf, 2014).

The testimonies of the asylum seekers who participated in this present study provide evidence of this imbalance between the two types of social capital, with the majority of the asylum seekers attesting to having relationships outside of their own community only with people in a professional capacity. The reason for this imbalance could possibly be explained by the fact that the majority of these participants were not working at the time of the interviews and Elliot and Yusuf's (2014) research highlighted an increased difficulty for refugees to form social connections with people from outside their community if they do not work. Notwithstanding this, an article that discussed the findings of a study carried out on a selection of European countries including Malta, affirmed the general lack of social contact between refugees and the Maltese population (Farrugia, 2009), irrespective of occupational status. An Australian study by Pittaway, Mull & Shteir (2009), identified the common barriers that refugees and migrants face to form external social connections, with one of the major barriers being exclusionary practices on the part of the host population. Similarly, marginalisation was a major finding in a study by Lynam and Cowley (2007) carried out in Canada and Britain amongst first generation migrant teenage girls and their mothers. These authors asserted that marginalisation is the consequence of dominant discourses that continuously reproduce the asymmetrical 'Us' and 'Them' binaries and further fuel stereotypical representations.

The findings of this present study are replete with instances which strongly infer that HCPs view asylum seekers as the ‘Other’, with narratives that evoke similar stereotypical images of asylum seekers as those depicted by society at large. In Chapter Four, Anna spoke about her general fear of ‘black’ men and reported that this could be because of stories that she had read, or because she feels that all ‘black’ men view women to be inferior. Other healthcare professionals spoke about how they themselves would stereotype ‘black’ people solely because of their skin colour and one of the nurses said that generally ‘black’ people were automatically thought to be asylum seekers and treated as “*second class citizens*”. Indeed, during both the interviews and informal conversations, the healthcare professionals often used “*asylum seekers*” and “*black people*” interchangeably. Another clear example of ‘Othering’ can be seen in Chapter Five where a nurse reasons that because of “*their*” different lifestyle, she had no wish to socialise with asylum seekers and was against their being integrated into Maltese society. These stereotypical assumptions have resulted in the exclusion of the asylum seekers in Malta and this is clearly evidenced by their lack of bridging capital as demonstrated above and which has resulted in marginalisation. Findings from a small qualitative study carried out with asylum seekers living in one of the Open Centres in Malta further corroborates this idea and showed that generally Maltese society is “closed” to these asylum seekers (Cameron, 2009).

The marginalisation of the asylum seekers participating in this study appears to have partially affected their navigation of the primary health care system because of a lack of opportunities for correct information acquisition. An example of how this impacts access can be seen in Chapter Six, which describes how during my observation, errors in access on the part of asylum seeker would occasionally result in loud recrimination by a staff member, with the potential of the asylum seeker failing to return.

Mobilisation of Resources

Successful navigation does not rely solely on the asylum seekers’ awareness of available services but it also requires access to a variety of resources and the ability to mobilise these (Dixon-Woods, 2005). These resources include availability of dependable transportation, telephones, interpretation services, support with childcare and some degree of flexibility at

work (World Health Organisation (WHO), 2010), all of which are dependent on socio-economic circumstances (Marmot et al, 2008).

All of the asylum seekers who participated in the in-depth interviews for this study, were either getting some form of support from non-governmental organisations, or other agencies on funded projects, or were living in one of the Open Centres. The type of health-related support that these organisations provided ranged from setting up appointments, to transportation, to interpretation services, to being accompanied by a nurse, or social worker on medical visits, to having a doctor available for them specifically a few hours three times weekly. Although the amount of support was variable, it was evidently of great help to people in relation to various aspects of navigation. For example, Simret in Chapter Six, said that being accompanied on a medical visit, especially in an emergency, meant that he was guided through the appropriate healthcare pathway of what was for him an unknown system, in the fastest time possible. Furthermore, Ndidi and Nkem both said that being accompanied provided them with help in communicating, emotional support and generally resulted in better care provision.

Instances such as these highlight the substantial heterogeneity amongst asylum seekers. The majority of asylum seekers who had some form of support, cited fewer difficulties in the specific health-related area than others whom I met during observation and who did not have similar support. Additionally, as discussed in the methodology chapter, I very possibly did not have access to extremely vulnerable asylum seekers, who because of their extreme vulnerability, are unable to access services. The difficulties associated with researchers accessing the “socially invisible” asylum seekers, whose vulnerable social locations result in a disconnection with mainstream society and a virtually insurmountable barrier to service access, have been reported in the literature (Shaghagi et al, 2011, p 87). The implications of this on representation of the asylum seekers in this study has been addressed in Chapter Three and highlighted as one of the limitations, which should be kept in mind when reading the findings.

The heterogeneity amongst asylum seekers is indisputable and their access to healthcare services is highly dependent on the social location in which they are positioned, that is in

turn determined by the intersections of multiple social identities such as race, class, gender and education (Weber & Fore, 2007). This heterogeneity is clearly demonstrated in this study through the pen portraits of the asylum seekers as provided in Chapter Three, showing variations in country of origin, gender, education, language, reasons for migration, religion, and immigration status, amongst others. The utilisation of an intersectionality lens has helped identify the diverse health experiences that arise from the intersection of various combinations of these 'markers of difference' within systems of oppression, such as ethnocentricity and which emerge from a colonialist creation of extreme binaries such as 'Us' and 'Them'. Various instances of this are demonstrated in the discussion below, with an obvious example being the different experiences and healthcare outcomes for asylum seekers engaging in clinical encounters that are linguistically concordant, in contrast to those engaging in encounters that are linguistically discordant.

As the findings in Chapter Five show, Patrick felt that he did not have any problems with navigating the healthcare system in Malta, claiming that this was a result of him being educated and because his country of origin had been colonised by the British, as Malta had been. Difficulties of navigation amongst asylum seekers I interviewed or observed was often a consequence of inadequate information and this factor has been highlighted as a major barrier to healthcare access in a substantial number of other international studies (Asgary & Segar, 2011; Boateng et al, 2012; Norredam, Mygind & Krasnik, 2006; Scheppers et al, 2006). In the present study, inadequate information often resulted in access errors, such as asylum seekers attending the wrong Health Centre in terms of catchment area. On the other hand, as described in Chapter Three, since cultural mediator services are only available in one of the Health Centres, there is the likelihood that some of the asylum seekers would purposely attend this specific clinic to avail themselves of these services. This is being suggested in view of Dixon-Woods et al's (2005) affirmation that the presence, or absence of interpretation services has a great impact on the permeability of healthcare services, which indicates that the lack of this service in the other health centres render them less permeable. This lack of interpretation services is further compounded by the lack of information leaflets in other languages apart from Maltese and English in all of

the Health Centres, which validates Weber & Fore's (2007) claims of how institutional structures can influence and reproduce inequalities.

Discriminatory Services & Practices

Restricted hours and an appointment system also render a service less permeable and the difficulties that asylum seekers face in relation to services with restricted hours was clearly demonstrated during my observational period. As described in Chapter Six, there was an asylum seeker who was required to attend the wound clinic for a daily change of dressing and this clinic was meant to close at 5pm. Invariably the asylum seeker would turn up at the clinic after 5pm, stating that his boss would not let him leave and refusing the nurse's suggestion to provide him with an explanatory official letter to give to his employer. HCPs' descriptions of similar situations in which asylum seekers demonstrated a fear of losing their jobs are dispersed throughout the findings and this could be the result of a lack of job opportunities that leaves them with no choice but to accept jobs that are both irregular and temporary and with working conditions that would be unacceptable by local standards (Farrugia, 2009). It is therefore encouraging to note that in September 2015, the prime minister of Malta claimed that the Maltese government was in the process of addressing these irregularities amongst 'migrants workers' ("Muscat calls for regularisation of 'migrant workers'", 2015, np). However, exploitation of migrants does not only occur when they are employed irregularly and even in the presence of a legal infrastructure, discrimination in relation to employment is still a common occurrence (European Network against Racism (ENAR), 2012 – 2013).

A study carried out in Ireland by O'Connell & McGinnity (2008), affirmed that migrants from non-English speaking countries were more likely to experience discrimination at work than Irish nationals, or migrants from English speaking countries and Fangen (2006) also claimed discrimination to be one of the major reasons for the lack of job opportunities. Additionally, ENAR's (2012 -2013) report that specifically addressed 'Racism and discrimination in employment in Europe' (np), listed five characteristics that would place migrants at higher risk of discriminatory practice at work. Four out of these five characteristics namely, being Muslim, having African ancestry, coming from non-EU

countries and being a woman “with a minority, or migrant background” (p 3) are common attributes, albeit with varying relevance, to the majority of asylum seekers who participated in this study.

Results from a Eurobarometer survey showed that 64% of the respondents believed ethnicity to be the most common cause of discrimination and furthermore, 46% believed discrimination in recruitment occurs on the basis of an individual’s skin colour, or ethnicity (European Union, 2015). As mentioned in the previous section, both institutional and individual discrimination towards minority ethnic groups has been found to be widespread in healthcare services. In addition to a negative impact on health and health-related behaviours, discrimination negatively influences migrants’ future healthcare encounters (Williams & Mohammed, 2009), especially in relation to under-utilisation of healthcare services (Burgess, Ding, Hargreaves, van Ryn & Phelan, 2008). Wamala, Merlo, Bostrom & Hogstedt (2007), carried out a large population based survey in Sweden with the aim of exploring the impact of perceived discrimination and socio-economic circumstances on helpseeking behaviour. The findings showed a relationship between healthcare access and racial discrimination, with perceived discrimination resulting in a percentage of the participants choosing not to utilise healthcare services in the future (Wamala et al). Similarly, findings from a study by Pollock et al (2012), also showed how migrants’ perceptions of discrimination impact negatively on their helpseeking practices, further justifying Dixon-Wood et al’s (2006) claim that the quality of healthcare provision and patient satisfaction has a strong impact on the permeability of healthcare services.

As can be seen in Chapter Six, there were a number of asylum seekers who reported that they had never experienced discriminatory practice in healthcare provision. The majority of asylum seekers who responded in this way were Somalians, who said that they were treated equally and further praised the fact that healthcare services in Malta are free. Caadil’s and Maryan’s citations show that their praise for healthcare service provision was based on a comparison with the inadequate healthcare services in Somalia and this is substantiated by other studies that have highlighted how a lack of reporting of discriminatory practices could be a result of refugees comparing the present situation in the host country to that in their country of origin (Fozdar & Torezani, 2008). There are varying

degrees and levels of discrimination ranging from subconscious to conscious discrimination and from discrimination on an individual level to that on an institutional level (Pollock et al, 2012). Findings from a systematic review by Shavers et al (2012) showed that migrants perceive discriminatory practice in healthcare provision to include inferior treatment, unfriendly, or condescending attitudes and stereotyping on the part of the providers. Furthermore, findings from Asgary and Segar's (2011) study showed that in view of all the other challenges associated with resettlement in a new country, issues such as housing and employment would take precedence over healthcare concerns. Prioritisation of concerns was evident in the interviews with Maryan and Baba, who were at different stages of a rejected status, which was an issue that for them appeared to overshadow all else.

It was only a small number of asylum seekers in this present study who specifically reported that they had been subject to discrimination in a healthcare setting but before any conclusions can be made, one need consider the findings from Kirkwood, McKinlay & McVittie's (2013) study. These findings demonstrated asylum seekers' and refugees' reluctance to expose racist acts against them, so as not to appear ungrateful to the host country. Furthermore, Goodman et al (2014) asserted that even when asylum seekers do complain, they do so cautiously and in relation to a system, as opposed to individuals. This could possibly have been the case during a discussion with Sabo about the lack of interpreters in healthcare, when after this discussion, she immediately spoke about how she could understand why these difficulties arose, in view of the problems that Malta faces by having to provide for so many asylum seekers. Notwithstanding this, Chapter Six shows how the few asylum seekers who reported a continuous cycle of discriminatory practices, asserted that this was due to racism on the part of the HCPs. Otherwise, the rest of the asylum seekers spoke about healthcare experiences which varied depending on the attending healthcare professional, with the majority of the HCPs being reported as providing non-discriminatory care.

During my observational data collection, I was exposed to instances of discriminatory care that mainly arose from a few of the HCPs' racialised and stereotypical assumptions. Chapter Five provides an example of this, when a doctor insisted on an Eritrean female

patient taking a pregnancy test, despite her claims that she had not had any sexual encounters. The stereotypical impression that female asylum seekers are a “*factory for children*” appeared to be rampant amongst the HCPs, often resulting in an insistence on female asylum seekers taking pregnancy tests when deemed necessary by the HCPs, even when the possibility of pregnancy was strongly denied by the asylum seekers.

Additionally, during the informal conversations and interviews with both the asylum seekers and HCPs, a substantial number of them recounted healthcare experiences and situations that unmasked discriminatory behaviour on both an individual and systemic level, although they did not name the behaviour as discriminatory. Apart from the obvious institutional discrimination that arises from a lack of interpreters which is discussed at a later stage, another example of discrimination on a systemic level would be the unofficial drive by the management to restrict all medical encounters to a ten-minute slot, as mentioned in Chapter Five. The discriminatory impact that this would have on asylum seekers is indisputable, in recognition of the additional time that healthcare encounters with this cohort of patients often warrants (Priebe et al, 2011). Furthermore, time restrictions and a taxing environment have been shown to result in doctors limiting the relational aspects of care (Lepiece, Reynaert, van Meerbeeck & Lorant, 2014). This results in care being provided mainly through a biomedical model, with little attention being paid to the social determinants of health, which is essential when addressing inequitable healthcare for asylum seekers (World Health Organisation, 2010).

The asylum seekers’ responses to discriminatory experiences in this present study were varied and generally affected some aspect of future healthcare access and behaviour. Nkem was one of the asylum seekers who reported having been exposed to discriminatory healthcare practice, mainly in the form of being spoken to in a very rough and aggressive manner by healthcare staff. She recounted how her response to this was by accepting all that the HCPs told her and refraining from asking any questions in future clinical encounters. Asylum seekers confronting the discrimination directly was another form of response that I observed, in addition to being told about similar instances by healthcare professionals. Chapter Five presents these accounts and shows how occasionally a confrontation would occur as a result of a misunderstanding that in turn would result in perceived discrimination. Magoon (2005) highlighted the negative effect that

discrimination has, irrespective of whether this discrimination is real, or perceived and Wahoush (2009b) argued that a significant number of these misunderstandings would not occur if healthcare providers explained the situation clearly. While there are instances in the findings of this study that show the veracity of this claim, an explanation of the situation was impossible in the case of the couple who had been given an incorrect appointment for a postnatal visit. In this specific situation because of the language discordance between the HCPs and the couple and in the absence of an interpreter, it was impossible for this couple to understand why they were being sent away without being attended to. This situation very possibly resulted in the couple perceiving the event as an act of discrimination, which could have had an impact on their future healthseeking behaviour.

The importance of linguistic understanding in healthcare communication can never be overemphasised and this understanding is not only a prerequisite for information acquisition and service permeability, but is essential throughout the stages of the healthcare pathway and will be discussed fully in the next section.

Permeability and Racism

Discrimination is closely interlinked with racism, as it is one of the forms through which racism is expressed (Paradies, 2006). Racism can be defined as a “multifaceted social phenomenon, with different levels and overlapping forms. It involves attitudes, actions, processes and unequal power relations and the forms of discrimination that flow from this.” (Garner, 2010 p 18). Essed (1991) introduced the concept of “everyday racism”, which refers to the processes of discrimination at the micro-level that are experienced on a daily basis and that in turn are shaped by the interactions between the dominant discourses at the macro-level and the categories of difference at the meso-level.

Essed further reported that “everyday racism” is expressed in three different main forms namely marginalisation, problematisation and containment. Marginalisation refers to an identification of ‘white’ people as representative of the normative group and this means that anyone who is not ‘white’ is excluded for being ‘Other’. As discussed above, this

appears to be highly applicable to the asylum seekers in the present study, whose narratives portray lives that appear to be generally experienced on the margins of 'main' society. Problematisation has been identified as another form of everyday racism (Essed 1991), wherein 'black' people are stereotyped as problematic, both to themselves and to others. Problematisation appears to be actuated by the majority, if not all of the healthcare professionals in this study, as can be seen in both Chapter Five and Six. These findings include remarks by the healthcare professionals, showing how they all generally believe that asylum seekers lack the necessary knowledge to care for themselves, even in very basic self-care activities such as hygienic practices. Additionally, these healthcare professionals highlight a number of challenges that they themselves face when providing care to asylum seekers. Examples of these challenges are clearly illustrated in Chapter Five where the HCPs recount the difficulties of medical encounters between stakeholders who are linguistically and culturally discordant. Moreover, as previously mentioned, the HCPs tend to blame the asylum seekers for the difficulties that they face, as opposed to a recognition of their organisation's failure to provide the essential resources such as readily available cultural mediators that would support healthcare professionals and ultimately, ensure equitable healthcare provision. Problematisation also occurs when 'black' people, or people of diverse cultures, are stereotyped by being assigned the same negative characteristics. This behaviour on the part of the healthcare professionals in this study is clearly evident with comments such as *"it's like they are still living in mediaeval times"*; *"in their culture, you rape a woman, its nothing!"*; *"I always saw disorganisaton, dirt, a large group of people all over each other, smells and ..."*; *"after all, they do come from the jungle don't they?"* strewn throughout their narratives. Containment, the third and last main form of "everyday racism" as described by Essed, refers to actions that repress retaliation to discriminatory behaviour, such as the use of intimidation, humiliation and a denial of racism. Chapter Six highlights an incident where a doctor describes a situation that she had witnessed where one of the nurses was talking to an asylum seeker in a racist and humiliating manner and instead of condemning this behaviour as racist, she tries to find excuses.

Further to identifying the occurrence of individualistic racism, an investigation into the various forms of racism on a political and institutional level is essential, not least because

of the way that it informs and permeates the above-mentioned interpersonal interactions (Desmond & Emirbayer, 2009). This form of racism has been termed structural racism, which is said to involve “macro-level dynamics that have micro-level consequences” (Powell, 2008, p 816) and which does not only compound existing inequalities but serves to create new ones (Viruell-Fuentes et al, 2012). There are various instances of this occurring throughout the findings and the ensuing discussion further highlights the impact of institutional policies and shortcomings, such as the lack of adequate interpretation services and staff support, that in turn negatively influence HCPs’ perceptions and attitudes towards asylum seekers and subsequent healthcare outcomes.

As can be seen by the above discussion, numerous factors have been identified in the findings of this study that impact on the asylum seekers’ access to healthcare services in relation to navigation. The asylum seekers in this study generally appear to have a substantial amount of bonding capital and this is the major source of information in relation to available services, although this appears to be inadequate, or incorrect, at times. Notwithstanding this, there is a great probability that there are asylum seekers who do not even have bonding capital, rendering them invisible and inaccessible. As a result, these extremely vulnerable asylum seekers are very possibly not represented in these findings.

Navigation and Permeability of Services: A Conceptual Overview

Marginalisation, discrimination and racism is created and reproduced through a dominant and reverberating discourse of ‘Otherness’ that spawns multiple inequities and further reinforces established systems of oppression (Van Dijk, 2002). The adoption of an intersectionality lens has highlighted the bleak reality of the asylum seekers in this study, who do not only have to contend with discrimination based on race, but have to face the consequences of unfavourable social positioning that emerges from the intersections of race with other markers of difference such as culture, religion, language and socio-economic circumstances amongst others. Additionally, the relevance of including the term ‘asylum seeker’ as a salient marker of difference has been identified following consideration being given to aspects of time and space, as intersectionality analysis demands (Grzanska, 2014). This has helped highlight the negative connotations associated

with the term ‘asylum seekers’, as these are generally viewed either as a burden, a fraud, or a threat (Olsen et al, 2016). This is a result of ‘Westernised discourse’, which is a product of a colonial past and further aggravated by political and media rhetoric within the present day context. This discourse infiltrates through the meso and micro levels to result in the above-mentioned systemic and individual oppressions, with their negative impact on navigation and permeability of services.

Appearances at Health Services

Identification of candidacy and successful navigation, result in individuals gaining entry to a health service and by so doing, attest that they have a legitimate claim to access this service (Dixon- Wood et al, 2006). The next stage, which is the initial phase of the healthcare encounter, is a dimension of the candidacy framework. This dimension is known as appearances, or presentations and helps determine the therapeutic outcome of the encounter. A successful outcome requires a number of skills on the part of all the people involved, namely the patients, the healthcare professionals and the frontline support staff (Dixon-Woods et al, 2005), within an equitable healthcare system (Kovandzic et al, 2011). In this encounter, the patients are required to prove their eligibility for candidacy and the healthcare staff pass judgement on this, depending on the clarity and credibility with which the asylum seekers are able to articulate their problems and needs (Dixon-Woods, 2005). Notwithstanding this, as will be seen in the ensuing discussion, whilst the onus of proving legitimacy of claim to access is generally placed on the asylum seekers themselves, the nature of the outcome is dependent on a variety of factors.

The quality of patient-provider communication is central to access and to effective health care provision and utilisation (Joshi et al, 2013). As the following discussion will show, despite attempts to achieve mutual understanding, the findings highlight how linguistic and cultural discordance among the participants impact negatively on clinical encounters, which in turn, jeopardise credibility in relation to the legitimacy of asylum seekers’ candidacy. The situation is further aggravated by the HCPs’ and frontline staffs’ typification of the asylum seekers and vice versa and by the fact that these interactions occur within an institutional environment whose policies do not always encourage, or

provide, the required support to ease the associated difficulties which would promote effective cross-cultural medical encounters. The term ‘chaotic bricolage’ has emerged as a thematic representation that epitomises the essence of these medical encounters, which, as can be seen by the ensuing discussion, have been influenced and shaped by the interplay of a variety of factors.

Linguistic Discordance

As can be seen in Chapter Five, a significant number of the asylum seekers and the vast majority of healthcare professionals in this study, referred specifically to language difficulties. However, the importance that they assigned to it varied tremendously, as did the strategies to overcome any language barriers that they faced. Language barriers have been cited as a hindrance to migrant access throughout the phases of the healthcare pathway (Garcia & Duckett, 2009). The impact of this is even more problematic in asylum seekers specifically because of the probability of them having complex healthcare needs (Correa – Velez, Johnston, Kirk & Ferdinand, 2008), as a consequence of the social locations in which they find themselves in. Linguistic discordance has also been highlighted as a major contributor to healthcare disparities (Smedley, 2012) and there is ample evidence of how language can impact on the quality of healthcare (Pithara et al, 2012). Many studies have shown that language discordance in clinical encounters can result in an increase in unnecessary testing and procedures (Access Alliance, 2009), diagnostic errors (Karliner et al, 2007), an inadequate amount of relevant information imparted (Harmsen et al, 2008), an increase in adverse events that are preventable (Johnstone & Kanitsaki, 2006), a lack of trust and dissatisfaction on the part of the patient and a raised potential for the occurrence of ethical uncertainties (Bhatia & Wallace, 2007). The majority of these negative effects is highly relevant to this study and have been referred to in a number of the participants’ testimonies, or observed during my time spent in the Health Centres, as the following discussion will show.

As mentioned earlier, the reception areas of the health centres where I carried out my observation are located in the general waiting area and therefore I had the opportunity to observe asylum seekers’ contact with the receptionists, which for some would be their first

ever contact with the health care services. As the findings in Chapter Six show, on those frequent occasions when a cultural mediator was not available, there were instances when the asylum seeker and the receptionist could not understand one another. This lack of understanding was inevitably worse the more complicated the encounter, such as when either the asylum seeker was requesting some information with regard to some aspect of a required service, or the receptionists were attempting to impart some information in relation to a service not being available on that day, followed by instructions on how to access that specific service. In these instances, there were times when the receptionists would raise their voices in the false belief that this would enable a better understanding but which only enabled the large number of people waiting around to become witnesses to the details of this interaction. Indeed, I occasionally heard a few of the receptionists loudly and pointedly asking a female asylum seeker if what she requested was a pregnancy test, or a gynaecological appointment, with no apparent awareness of the asylum seeker's feelings of embarrassment and shame that these loud questions could generate. Additionally, there were other instances when feelings of frustration on the part of a small number of receptionists were made evident to all through the irritated tone and rough manner of their responses.

A study carried out by Komavic, Bedford & van Driel (2012) corroborated the above-mentioned undesirable behaviour through their participants' reports of how medical receptionists were generally hostile and lacking in civility, especially in the presence of language discordance. The participants in Pollock et al's (2012) study also reported instances of receptionists being unapproachable because of their lack of friendliness and they further highlighted how migrants' ability in the language of the host country was an important variable that influenced the attitude of the receptionists. Recounting a personal experience about attending a doctor's clinic with her father, Chiem (2006) poignantly described how a receptionist's behaviour that imparted an attitude of superiority and disapproval, resulted in feelings of undeservingness and shame on her part, which, in addition to her upbringing that endorsed a respectful demeanour, rendered her unable to respond in kind, leading her to refuse a follow-up appointment.

None of the asylum seekers that I interviewed referred to the receptionists at any stage and the nature of the data collection did not provide information in relation to the impact of the receptionists' behaviour in terms of asylum seeker access, such as failing to return for follow ups. Despite this, my observational data of the interactions, in addition to Dixon-Wood et al's (2005) assertions that all interactions within the clinic influence helpseeking behaviour, indicate that further exploration of this issue is warranted.

If the encounter with the receptionist has been successful, then the next phase in the asylum seeker's healthcare pathway would be interaction with a healthcare professional. Apart from one of the nurses, all the other healthcare professionals referred to the language barrier as being one of the most challenging aspects of providing care to asylum seekers. As mentioned in the findings, it is a matter of concern that there was one nurse who was oblivious to the probability of important information not being disclosed because of language barriers and the resultant negative impact of this. Meeuwesen (2011) referred to this attitude as the "no problem" (p 20) approach to language barriers and further highlighted how this approach is generally accompanied by an oversimplified view of crosscultural communication and the opinion that it is the migrants' responsibility to provide interpreters. Despite this "no problem" approach appearing to be attributable to only one of the healthcare participants in this study, the shortage of cultural mediators in the Health Centres strongly suggests an administrative disposition to place the responsibility of linguistic understanding on the asylum seekers. As mentioned previously this situation has improved to a certain extent and since 2015, a cultural mediator has been available daily during office hours, from Monday till Friday in the health centre that caters for the largest number of asylum seekers.

Because of the lack of cultural mediators during the data collection phase, a substantial number of the asylum seekers often provided their own interpreters by bringing family, friends, or acquaintances along with them to a medical visit. Furthermore, when there was no official cultural mediator available and the asylum seekers had not brought someone with them who could help with the interpretation, they would often attempt, or be asked by the attending HCP to find someone in the waiting room that would help establish a basic understanding in the ensuing clinical encounter, regardless of the fact that this person

would be a complete stranger. This is similar to the findings in MacFarlane et al's (2009) study, wherein generally, the asylum seekers were burdened with the responsibility of ensuring linguistic understanding during the medical encounter, despite their limited resources.

There is substantial literature that highlights the deficiencies associated with utilising informal interpreters, whether they are family, friends, acquaintances, or strangers. These deficiencies include nondisclosure of symptoms of a sensitive nature, noncompliance with prescribed treatment, a lack of clarity in relation to the outcomes of the encounter, a dissatisfaction with the process and a resultant mistrust of the healthcare professionals and/or system (Hudelson & Vilpert, 2009; Johnstone & Kanitsaki, 2006; Macfarlane et al, O'Donnell et al, 2008). As evident from the findings of this present study, the mistrust was not solely on the asylum seekers' part but in some of the instances, the healthcare professionals felt that the informal interpreter, especially when he or she was known to the patient, was choosing what to translate to the patient and vice versa and would at times provide an answer without consulting the patient.

Following a study that was conducted through a sociolinguistic analysis, Aranguri, Davidson & Ramirez, (2006) concluded that when translating, there were three types of changes to the original text that untrained interpreters knowingly made, namely "content revisions", "content omissions" and "content reductions". "Content revision", which refers to alterations being made to the original information is the most common practice amongst informal interpreters and similarly to the other types, is a major hindrance to patient presentation and decision-making and to the provision of the understanding necessary for fair adjudication by the HCPs (Meeuwesen, Twilt, ten Thijs & Harmsen, 2010, p626). A case of "Content revision" in this present study can be seen in Chapter Five of the findings, through a description of a situation where a nurse who had a basic knowledge of Arabic realised that the informal interpreter was translating incorrectly. The findings further show how other HCPs also feel that utilising informal interpreters could result in misinformation, with one of the doctors stating that he is sure that this occurs when the husband who would be translating for his wife, disagrees with what the doctor is asking or

suggesting and therefore refrains from translating that part of the conversation and replies in place of his wife.

During the observational data collection and as illustrated in Chapter Five, I also witnessed situations where there was a lack of mutual understanding between the asylum seeker and the healthcare professional, despite the presence of an informal translator. In these instances, one would question the accuracy of the interpreter's basic description of the patient's reason for attending the clinic and despite the need for further clarification this was not forthcoming. This could either be because of a lack of language proficiency on the interpreter's part, or because of a lack of familiarity with the technical terms being used (Macfarlane et al, 2009). The authors just referred to additionally reported how when an asylum seeker was accompanied by an informal interpreter, who him/herself was not linguistically proficient, after the clinical encounter, both the patient and the translator, would, after the clinical encounter, try "patching" the bits of information that each of them had understood, in an attempt to gain better understanding of the consultation (Macfarlane et al, 2009, p 213).

In this present study, in situations where a physical examination could lead to a diagnosis, such as tonsillitis or a chest infection, then a diagnosis would be made with minimal information about the illness and the prescribed medication being imparted to the patient through the interpreter. Even in this situation one would question how much of the information, however brief, was actually understood. In the event that the diagnosis was impossible to ascertain because of linguistic discordance, investigations were usually ordered to establish a diagnosis. An example of this occurring is found in Chapter Five that describes a situation where an asylum seeker came to the doctor's clinic with a friend of his as an interpreter. The interpreter's English was very poor and apart from the fact that the patient was complaining of flank pain, it was impossible to gather any further medical history. As the doctor explained, she was practically certain that this was a muscular disorder but due to the lack of further information, she was unable to rule out kidney disease. She therefore prescribed anti-inflammatory drugs in the event that it was muscular pain and sent the patient for a urinalysis and further investigations. These types of incidents result in a double bind situation, because while the uncertainty that arises out of a

lack of mutual understanding leads to a raised number of investigations being ordered, the practice appears to fuel asylum seekers' suspicions of interventions being carried out on them for ulterior motives, such as providing training opportunities for medical students as Meraf asserts in Chapter Five.

Linguistic Discordance: Trust & Distrust

Trust is a multidimensional concept that has been found to be highly influential in various phases of the healthcare pathway (Halbert, Armstrong, Gandy & Shaler, 2006). Distrust amongst asylum seeker minors generally is rooted in unison of past and present experiences, within a historical context of oppression and exploitation (Raghallaigh, 2013). Furthermore, both individual and medical distrust has been found to be generally higher in ethnic minorities (Kennedy, Mathis & Woods, 2007), with conspiracy theories related to specific diseases and 'Western' medicine widely held as true amongst various African communities and diaspora (Bogart, Wagner, Graham & Banks, 2010; McCoy, T, 2014). This medical distrust has arisen following years of colonial domination and exploitation of African countries that was in part facilitated by the introduction of tropical medicine as a "benevolent European gift" (Baronov, 2008, p1), which in turn, strengthened 'Western' domination through its silencing of indigenous knowledge (Abdullahi, 2011). Medical distrust was further provoked by abusive research studies carried out in later years (Ball, Lawson & Alim, 2013).

In the present study, distrust was only referred to directly by two of the cultural mediators and both directly and indirectly by a few of the asylum seekers during informal conversations. As can be seen in Chapter Five, in addition to language barriers and a lack of understanding in relation to the necessity of investigations, distrust could also arise from unsatisfactory healthcare outcomes on the part of the asylum seeker. This is evident in one of the asylum seeker's testimonies where, in a manner that clearly showed his dissatisfaction, he described a situation when he was certain that he was unwell and despite investigations being taken, was sent home and advised to drink water by the doctor. There are a number of organisational and interpersonal factors that have been identified as having a negative impact on trustful relations and which are relevant to this study. These include

linguistic discordance, services that have a low permeability, incongruent expectations of the clinical encounter, bad experiences in the past and healthcare professional approaches including discriminatory behaviours, perceived or otherwise (Ngo-Metzger et al, 2006).

Similarly, a distrust of asylum seekers was referred to by some of the healthcare professionals, as well as demonstrated during observational data collection. In these cases, the distrust appears to be mainly related to the healthcare professionals' belief that they would not be provided with a full and truthful medical history necessary for reaching a correct diagnosis. They ascribed this mistrust to factors that arose out of stereotypical characteristics, originating from a postcolonial discourse of difference and 'non-Western' inferiority and attributed to all of the asylum seekers on a hierarchical scale. As can be seen in both Chapter Five and Six, the HCPs further reported that these characteristics would often result in a lack of full disclosure, an inability of the asylum seekers to coherently verbalise their problems because of low or non-existent health literacy, or different illness explanations that could result in patient presentations that would mislead them in their diagnosis. This is another instance of problematisation by the healthcare professionals, which as discussed above, can be regarded as a main form of "everyday racism" (Essed, 1991).

Several studies have highlighted doctors' concerns about making a misdiagnosis, or the way that they would question their ability to reach a diagnosis because of language difficulties (Gonzalez-Espada, Ibarra, Ochoa & Vargas, 2006; Kalengayi et al, 2012; Lawrence & Kearns, 2005; Taylor, Nicolle & Maguire, 2013). The situation is further aggravated if one considers the findings from a study which showed how doctors tend to have less contact with patients from a minority ethnic group during consultations, in terms of receiving and relaying information and checking patient understanding (Shouten, Meeuwesen & Harmsen, 2009). Moreover, due to issues of embarrassment and the power differentials at play, migrants have been reported to refrain from asking for further clarification (Wallace, DeVoe, Rogers, Malagon-Rogers & Fryer, 2007), as well as feigning understanding (Kale & Syed, 2010). In this present study, as evidenced in Chapter Five, the HCPs' testimonies refer to various asylum seekers assuming this type of behaviour, while this approach was also apparent during my observations of clinical

encounters. Indeed, there were numerous instances when it was clear that patients did not understand the information being given but when asked, indicated that they had understood. During their interviews, the healthcare professionals also reported similar responses by asylum seekers.

As mentioned previously, both the nurses and doctors spoke about the difficulties that arise out of linguistic discordance in clinical encounters. Notwithstanding this, the nurses generally indicated that through the utilisation of various strategies, such as gestures and pictures, they felt that they would ultimately manage to establish a very basic form of mutual understanding that would enable them to respond to the asylum seekers' needs. The doctors also spoke about attempting to enable mutual understanding through using similar strategies but further reported that these attempts were often unsuccessful. This is possibly due to the different nature of nurses' and doctors' roles, wherein making a medical diagnosis and the prescription of medications are not part of the nurses' remit. Whilst the nurses asserted that generally they could satisfy the asylum seekers' needs, gestures and pictures are hardly conducive to eliciting a holistic understanding of these needs. In situations of linguistic discordance nurses tend to place a sole focus on the physical needs, with no consideration being given to the psychosocial aspects of care (Meddings & Haith-Cooper, 2008). This is a matter of concern in view of the asylum seekers' expectations of a holistic approach to care, as has been mentioned before. This is corroborated in the findings of a systematic review by Paternotte et al, (2015), which illustrated the importance that migrant patients place on being viewed as individuals by HCPs and in full awareness of the relevant social context.

The doctors' role in the GP clinic in the Health Centres mainly consists of carrying out a medical and physical assessment with the aim of gathering enough information to make a diagnosis, monitor a chronic illness, or to guide the patients through the relevant investigative process, followed by a prescription of the appropriate treatment and advice. As a result, a misunderstanding could lead to unnecessary investigations and medication errors (Johnstone & Kanitsaki, 2006; Karliner et al, 2007; Priebe et al, 2011) and as we see in Chapter five, Tony's impassioned account of the lack of interpreters clearly showed the extra pressure that this situation places on him and the other doctors, who are fully aware

of the raised risk of errors occurring, but who seem to feel helpless and unable to do otherwise. Tony further highlighted how these risks are multiplied in emergency situations which additionally also give rise to the ethical dilemma of not providing the necessary information to enable informed consent to be given. Informed consent includes both an ethical perspective based on human rights, as well a legal one (Rao, 2008). Tony's concern appeared to be directed at both perspectives, where he showed disapproval of the paternalistic role which he involuntarily assumes in these situations, as well as a preoccupation with being charged with an offence in the event of a medical error occurring. Any such offence would be deemed to be much worse in the absence of informed consent.

For informed consent to be considered valid, the healthcare professional is required to provide the necessary information that would enable a "voluntary choice" (Applebaum, 2007, p 1834). It is indisputable that this is impossible to achieve in the absence of linguistic understanding and moreover, findings from a study by Hunt & de Voogd (2007) demonstrated that even when informed consent is given during cross-cultural consultations with the support of informal interpreters, these migrants would still only have a limited understanding of the information provided. These same authors reported that this is often a result of the interpreters' low level of linguistic proficiency and medical knowledge, as well as other issues discussed above, such as decisions being taken by the interpreter without consulting the patient. It is of concern to note that the participants of the study just referred to, signed the consent form for an amniocentesis procedure following an abnormal blood test result, unaware that they lacked important information such as the benefits and risks of the procedure, possible alternatives and most importantly that the procedure was voluntary (Hunt & Voogd). The lack of knowledge with regard to one's right to choose is of even more concern, when one considers how asylum seekers' choices are already diminished because of the power differentials that are prevalent in migrant and healthcare professional encounters (Dauvrin & Lorant, 2014).

While some of the healthcare professionals in this present study referred to asylum seekers being generally submissive and unquestioning of the medical advice given, none of these healthcare professionals appeared to consider that this disinclination to question is often a

consequence of the power imbalances that are entrenched in clinical encounters. The healthcare professionals' lack of recognition of their dominant position and the influential effect that this position has on asylum seekers' access to health is somewhat paradoxical, in view of these same healthcare professionals' protestations against the influence that 'Muslim' men exert over their wives' healthcare practices when they accompany them to a consultation. This reaction on the healthcare professionals' part is possibly a manifestation of a generally paternalistic approach to care, which is a byproduct of a biomedical model of healthcare provision.

As can be seen from the above, the numerous negative effects that result from a linguistically discordant clinical encounter greatly contribute to disparities in health and inequitable healthcare provision and the availability and utilisation of formally trained medical interpreters has been found to result in an improvement in a number of areas and quality of care generally (Karliner et al, 2007). As can be seen in Chapter Five, none of the asylum seekers of this present study showed any preference between formal and informal interpreters and similarly to the participants in Hunt and Voogd's (2007) study above, they appeared to be oblivious of any instances of miscommunication while using informal interpreters. Conversely a substantial number of the healthcare professionals, especially the doctors, spoke about the benefits of having formal interpreters and their positive impact is corroborated by the literature (Flores, 2005; Karliner et al). Notwithstanding this, a number of the healthcare professionals further revealed their reservations of having male interpreters with female patients, which is of especial concern when one considers that throughout the course of my data collection, the cultural mediators when available, were all male. One of the cultural mediators whom I interviewed felt that this was not a problem, citing that the advantages of the professional service provided far outweighed the gender issue. Verily, none of the female asylum seekers in my study referred to this matter in relation to interpreters, although they did say that whilst they have never refused being attended to by a male doctor, if they had a choice, they would prefer a female doctor. The gender of the interpreter has been found to be an important factor for female migrants, especially in encounters that require a physical examination, or disclosure of information of a sensitive nature (Hadziabdic & Hjelm, 2014). This has been highlighted as a potential

cause of non-disclosure (Juillard et al, 2008), which in turn, has a negative impact on healthcare access at the ‘appearances’ stage of the process.

Despite the indisputable benefits of utilising a trained formal interpreter, in addition to the potential negative outcome of gender discordance, there are other difficulties associated with their use (Juillard et al, 2008; Sheikh, 2014). One of these is in relation to the added challenges in the development of a therapeutic doctor-patient relationship (Rosenberg et al, 2007), especially in view of the short time frames that are synonymous with GP clinical encounters. This highlights the importance of healthcare professionals being educated on the optimal strategies to be utilised in these encounters (Bansal, 2013). None of the HCPs in this present study had ever undertaken any training in relation to working with interpreters and additionally, this was not mentioned by any of them as a topic that they would like to see included in any future transcultural educational programmes. This is yet another cause of concern, since the presence of a medical interpreter may further broaden the imbalances on the ever present power differentials, resulting in patients placed in an even “weaker position” (Fatahi, Hellstrom, Skotti & Mattson, 2008, p 42), further aggravated by an inadequate spatial positioning. As described in Chapter Three, the GP rooms are generally very small, with a desk placed between the patient and the doctor and even if the doctors were aware of the optimal spatial arrangements, this favourable positioning could not be actuated because of the environmental constraints.

The challenges associated with linguistic discordance are exacerbated further by interactions occurring between people with differing cultural norms (Wearn, Goodyear-Smith, Everts & Huggard, 2007). As can be seen by the findings of this study and the following discussion, there is the potential for additional misunderstandings to occur in cross-cultural consultations as a result of this cultural discordance.

Cultural Discordance

As described in Chapter Five, for the majority of the HCPs in this study, ‘culture’ is conceived as a static construct that guides behaviour and lifestyle, based on the values, beliefs and characteristics that are common amongst a group of people, such as those

sharing a nationality, or in this case, a continent. While there is a general tendency for HCPs to group asylum seekers together and accredit them with stereotypical characteristics that differentiate ‘Them’ from ‘Us’, the findings also show that these asylum seekers are further placed on a hierarchical ranking.

Cultural Discordance: Hierarchical Ranking

Ranking appears to be dependent on the intersectionality of various markers of difference, with more markers resulting in a lower ranking. As can be seen in Chapter Five this approach tends to result in Somalis being placed on the lowest rung because in addition to them being ‘asylum seekers’, ‘black’ and economically deprived, the majority of them do not speak English or Maltese, have not had the benefits of an education and are Muslim. Jamaal, a Somali cultural mediator, described how asylum seekers who are educated, wear Western clothes and can speak English or Maltese, are treated differently by HCPs in medical encounters, as well as by the general public. This is a strategy wherein “whiteness” is assigned to those migrants whose beliefs and behaviours are akin to those of the host population, and “blackness” to those who are physically and ideologically different, with “whiteness” uncritically considered to be the superior and desired trait (Ajrouch & Kusow, 2007, p 73)

A nurse whom I interviewed reported that generally, attitudes towards asylum seekers were strongly influenced by the asylum seeker’s skin colour and religion, possibly due to the strong influence that the Roman Catholic Church in Malta has over civic society (Falzon, 2007). This attitude is further corroborated by Borg and Mayo’s (2006) historical account of the rejection of Islam by the Maltese and which Darmanin (2013) argued has re-emerged in certain periods along the years such as in response to the Maltese themselves being ‘Othered’ as Saracens, when colonised by the Order of St John. The islamophobia that arises out of a perceived threat of Maltese and Roman Catholic values, which a substantial number of people believe to be intrinsically linked, is a reality in Malta. This was clearly demonstrated by some of the Maltese people’s reactions to a large group of Muslims congregating to pray outside a Roman Catholic church. The media reported that the event was seen as either “an act of provocation”, or a confirmation that ‘their prophecy

of Catholic Malta in the grip of Islam was well on its way to being fulfilled” (“Jumu’ah on the Msida seafront”, 2016, np). In addition to this and as mentioned previously, islamophobia is aggravated by present day ‘Westernised’ discourses that foster a climate of fear and distrust. This is highlighted in the World Report produced by Human Rights Watch (2016), which affirmed that ‘blatant islamophobia and shameless demonizing of refugees have become the currency of an increasingly assertive politics of intolerance’ (p 1).

Most of the HCPs in this study associated being Muslim with the subjection of women to a patriarchal system and which they reported to find challenging, when encountered. ‘Western’ societies place great value on the respect for autonomy, which is one of the four bioethical principles, as identified by Beauchamp & Childress (2008) and perhaps because of this, a number of these HCPs described how, if their patient was female and her male partner was present and continuously talking on her behalf, they would pointedly ignore him and insist on speaking directly to the patient and encourage her to respond. These HCPs proudly reported their actions in the belief that they were empowering these women and safeguarding their autonomy. Conversely, during an informal conversation with an asylum seeker as reported in Chapter Six, this woman described how HCPs’ disregard of her cultural norms, specifically in relation to the patriarchal system that she adhered to, resulted in her experiencing feelings of discomfort and disempowerment. This asylum seeker’s response is corroborated by the findings of a study that show how a lack of cultural sensitivity and understanding on the part of the HCPs can result in feelings of depersonalisation and furthermore, create a barrier and influence ‘appearances’ (Pollock et al, 2012). This approach on the part of the HCPs was also found to be utilised in a study of GP experiences, wherein it was the patients who were expected to renounce their cultural norms and in so doing, achieve some form of cultural alignment in the medical encounter (Rosenberg et al, 2007). This is an example of “moral imperialism” and the conviction that bioethical principles based on ‘Western’ values are superior and can be applied universally (Chattopadhyay & De Vries, 2013, p 643).

As we see in Chapter Five, the HCPs in this study further spoke about their concerns related to assuming behaviours, or instigating conversations that could be deemed inappropriate by the asylum seeker. A very small number of these HCPs countered this uncertainty by taking the initiative and searching for information, which in combination with experience, made them feel competent to deal with cultural diversity. However, for the rest, this uncertainty was on going and influenced their interactive behaviours. So much so that a substantial number of the nurses recounted how when caring for an asylum seeker, they would keep conversation to a minimum and refrain from asking personal questions for fear of being inappropriate and causing offence, or rekindling traumatic memories.

These feelings of uncertainty have been highlighted in the literature (Kai et al, 2007) and the above-mentioned behaviour has been described as a common strategy utilised by healthcare professionals to avoid any friction from occurring between the diverse cultures (Wachtler et al, 2006). Apart from this approach being uncondusive to the development of a therapeutic relationship, it fails to satisfy migrants' expectations of an individualised and contextualised approach to care. Moreover, it is important for HCPs to get to know patients for who they really are, since stereotyping can arise out of insufficient 'knowing' (Paternotte et al, 2015). The HCPs in my study, especially the nurses, equated a good knowledge of the 'Other' person's culture as the cornerstone of 'knowing' and therefore essential to achieve culturally competent care. This reasoning gives evidence of how these HCPs adhere to an essentialist view of culture (Cooper, Beach, Johnson & Inui, 2006) which when combined with uncertainty, results in a subconscious grasp of stereotypical images of the 'Other' that shape their transcultural interactions and healthcare practices.

There is further evidence of this in Chapter Five of the findings, wherein a doctor described a situation where she did not offer a Muslim patient the contraceptive pill, which was one of the main options to treat the symptom this patient was suffering from. The reason for this was because of the doctor's self-perceived lack of knowledge on Islam's views of this medication. Avoidance tactics by HCPs of any issues deemed to be

potentially controversial in cross-cultural consultations have also been identified in other studies, with the potential of missing out on essential information (Kai et al, 2007; Peckover & Chidlaw, 2007). However, some authors argued that feelings of cultural incompetence in HCPs, both on a personal and on an institutional level, could be positive in that it could encourage critical reflection by the practitioners, which has the potential to lead to learning, as well as encouraging advocacy for institutional changes (Swartz, 2007). This does not seem to be the case with the HCPs in this study who, despite showing concern about the possibility of asylum seekers' having unmet needs, generally attributed these unmet needs solely to the asylum seekers' linguistic, or cultural differences, with minimal awareness of the impact that other macro and meso conditions have on these crosscultural encounters. Additionally, there seemed to be a lack of awareness of how these multiple factors intersect to negatively impact on all the phases of asylum seeker access to the healthcare pathway, including the dimensions of 'appearances' and adjudications.

Appearances at Health Services: A Conceptual Overview

As can be seen from the above discussion, healthcare encounters are a major source of health inequities as despite good intentions, interactions occur within a surrounding which is beset by an insufficiency of resources that in turn produce uncertainty and distrust amongst all the stakeholders. Furthermore, dominant discourses and essentialist notions of culture that subconsciously condition HCPs' judgments shape these encounters, as do the asylum seekers' expectations of healthcare provision, which is generally in conflict with a biomedical approach. Finally, the Eurocentric perspective that the majority of the HCPs demonstrate, serves to magnify the various intersectional categories and propagate the ever-present power differentials that recursively reinforce the dominant discourses and social structures on the macro and meso levels.

Adjudications, Offers and Resistance

Adjudications refer to HCPs' responses to the patients' presentations and is a dimension of candidacy which is highly influenced by the perceptions that healthcare professionals and

support staff have of ‘deservingness’. Such perceptions are often based on stereotypical assumptions that are socially constructed (Dixon-Woods et al, 2005) and further reinforce a view of the asylum seeker as the ‘Other’ (Grove & Zwi, 2006). Language and discourse can impact on the development of these stereotypical assumptions that have the potential to produce, legitimise and reproduce “unequal power relations” (Cui, 2010 p 19) and also to influence perceptions of ‘deservingness’ amongst the various stakeholders (Larchanche, 2012).

The findings of my study give credence to this argument as evidenced by the upcoming discussion, which shows how the HCPs’ attitudes towards asylum seekers are dependent on historical, political and neoliberal discourses and socio-economic conditions that subconsciously shape HCPs’ perceptions of asylum seekers and as a result, their deservingness. Deservingness of healthcare provision is not solely determined by legal entitlements but has an additional moral dimension and this indirectly impacts on access during the adjudications phase (Willen, 2012). Additionally, the ensuing investigations, treatment, or advice that the HCPs prescribe, which in the candidacy framework are known as offers, are highly dependent on their adjudications (Dixon-Woods et al, 2006). Moreover, patients may choose to either accept or refuse these offers, often depending on their feelings of trust, or mistrust of the attending HCP that emerge from the clinical encounter (Dastjerdi et al, 2012). As a result of the interdependency between these dimensions, adjudications and offers and resistance will be addressed together in this section.

Deservingness

The HCPs’ perceptions of asylum seekers’ deservingness as recipients of health and social welfare benefits appear to be rather ambivalent, with narratives that demonstrate a medley of conflicting reactions including pity, frustration, understanding, lack of understanding and fears of service sustainability amongst others. Despite this fear of service sustainability, the fact that asylum seekers should be treated at the Health Centres was not called into question by the HCPs. However, their responses strongly suggested that they viewed this healthcare provision as a charitable arrangement as opposed to a human right.

This was implied by the regular use of the Maltese utterance “*minn fuq*”, which loosely translates as “*after all that we do for them*” and this utterance littered HCPs conversations when they were discussing certain responses by the asylum seekers that they deemed to be inappropriate and ungrateful, such as the doctor’s narration in Chapter Six.

An article by van Oorschot (2006) presented the findings of a study that utilised a secondary data source to explore deservingness perceptions for welfare amongst the populations of 23 European countries. Five criteria were identified that the researcher concluded were correlated to levels of deservingness. the welfare recipient’s attitude was one of the criteria, with behaviours such as compliancy, conformity and gratitude being equated with raised perceptions of deservingness. Personal experience, as well as anecdotal evidence, suggest that both ‘patient cooperation’ and expressions of gratitude are highly rated by HCPs in Malta and are behaviours that are considered to be desirable traits in patients, irrespective of who they are. Moreover, the HCPs’ narrations showed that cooperation and gratitude were especially expected from asylum seekers “*after all that we do for them*”, and an HCP further recounted a story when a doctor refused to treat an asylum seeker because of what she considered to be the asylum seeker’s ungrateful and inappropriate behaviour and so adjudicated him to be undeserving of care provision.

As can be seen in Chapter Five, another of the doctors who participated in my study, revealed how she judged deservingness through whether the patients’ appearances showed ‘need’, or otherwise. In this specific case, deservingness was not so much related to health service utilisation in the form of medical consultations in the Health Centres, which are free irrespective of means testing but this doctor was referring to the provision of free medication. In these specific cases of free medications, Maltese nationals are entitled to free medication if, based on means testing, they are entitled to social benefits. As the findings show, the above-mentioned doctor described how she would use specific strategies to convince asylum seekers to buy their own medication when she was caring for someone who was wearing designer clothes, or was in possession of an expensive mobile. This doctor’s adjudications of non-deservingness would result in her using specific tactics to persuade the patients that it would be beneficial for them to buy their medications. This doctor further emphasised that she uses this approach with all patients who are entitled to

free medication, irrespective of nationality, ethnicity or skin colour. Notwithstanding this, an intersectionality approach shows how established “systems of domination” are further propagated by the intersection of markers of difference, in various ways and on different levels (Dhamoon & Hankivsky, 2011, p 24) and therefore, being black, uneducated, socioeconomically deprived and an asylum seeker would intersect with processes such as essentialism and racialisation in a particularly damaging manner.

Appearances that belie poverty were also brought up by other HCPs as a negative aspect when debating asylum seekers’ deservingness and Willen (2012) contended that this response is accentuated in a climate where asylum seekers are already viewed as an “unwanted burden”. Whilst it is the unauthorised migrants who are generally considered to be “parasites”, or “freeloaders” (Grove & Zwi, 2006, p 814), the majority of the HCPs in my study did not make any differentiations between asylum seekers on different statuses and, similar to popular discourse, would occasionally refer to all asylum seekers as “*illegal migrants*”, or “*clandestines*”. Despite this and as referred to above, the HCPs generally felt that whilst the asylum seekers were in Malta they should be provided with free healthcare services and this adherence to a moral standard despite financial concerns was also evident amongst healthcare providers in a study carried out in the USA (Marrow, 2012).

As can be observed in Chapter Six, the majority of the HCPs in my study were of the opinion that service abuse is *not* highly prevalent amongst asylum seekers and this had a positive impact on their perceptions of deservingness. Contrarily, perceptions of deservingness diminished because of what HCPs’ viewed as the irresponsibility of asylum seekers to bear numerous children despite their inability to provide for them and in so doing, place an increased demand on Maltese government services. The HCPs did not appear to consider that these perceptions of deservingness would have any bearing on the healthcare encounter generally, or their adjudications. Indeed, the majority of the HCPs repeatedly asserted that they treated asylum seekers no differently from any other patients, unaware of how macro and meso forces impact on perceptions of deservingness (Willen, 2012), which in turn influence the synergy in crosscultural medical encounters and ultimately, patient outcomes.

All of the HCPs in this study generally view asylum seekers as lacking in health literacy and further believe that this, in combination with cultural and other social factors, results in non-compliance with medical instructions, including follow up appointments. In the discussion that addressed the dimension of adjudication, Dixon-Woods et al (2006) further highlighted the relevance of an HCP's assessment of a patient's ability to comply with prescribed medication and/or advice on subsequent offers. The HCPs' views in the present study are similar to findings from a study by Oliver, Wells, Joy-Gaba, Hawkins, Nosek (2014), wherein the participants who were all doctors, showed a strong preference for 'white' patients in relation to 'black' patients, claiming that between the two groups, the 'white' patients were more "medically cooperative" (p 177). This preference for 'white' patients was also found in a study amongst registered nurses in the USA (Haider et al, 2015). As mentioned previously, these perceptions are a consequence of a postcolonial view of the 'Western world' as the sole location of knowledge and which creates binaries such as 'Us' and 'Them' that lay the foundations for racial stereotyping and explicit, or implicit biases that could impact "people's responses on a continuum of possible judgements" (Greenwald & Krieger, 2006, p 950).

The findings of the present study show that whilst the HCPs did exhibit signs of frustration when they were speaking about asylum seekers' non-compliance to treatment and advice, they reported that their decision-making about medical treatment does not differ to that with other patients, irrespective of their perceptions in relation to patient cooperation. However, implicit biases, which arise out of unacknowledged stereotypical images of the 'Other', may subconsciously influence HCPs' offers (Chapman, Kaatz & Carnes, 2013), although the evidence on the impact that implicit bias has on decision-making and treatment is contradictory and inconclusive (Blair, Steiner & Havranak, 2011). Despite evidence of discriminatory practice as discussed in a previous section, the nature of my data collection methods did not enable me to specifically discern differential decision-making behaviour on the part of the HCPs. Notwithstanding this, the findings and discussion above, particularly the section on navigation, are littered with situations and narratives that exhibit the HCPs' stereotypical assumptions. This is of extra concern when

one considers the connection between the large number of patients who attend the Health Centres and the uncertainty surrounding cross-cultural primary healthcare provision with evidence that illustrates how in situations of diagnostic uncertainty and time pressures, there is an increased tendency for healthcare professionals to fall back on stereotypical assumptions (Tait, Chibnall & Kalauokalani, 2009).

The asylum seekers also bring their own biases to the clinical encounter based on their past experiences, as well as stories that they have heard from other asylum seekers. These preconceived images, in addition to the level of trust that develops during the encounters amongst the asylum seekers and the healthcare professionals involved, impact on their responses to HCPs' offers (Feldman et al, 2006). This is seen in Chapter Five, which describes a situation that I observed, wherein an asylum seeker came to the GP clinic for the third time, complaining of having had joint pains for the last 3 months. Sometime previously another doctor at the same clinic had seen him for the same complaint and this doctor had sent him for blood investigations, also prescribing analgesia. The patient then returned on another occasion for the results of the investigations, which were negative for any abnormalities. On this second visit, the patient was seen by a different doctor, who advised him to continue with the analgesia previously prescribed, but did not provide any further information. On the third visit, the asylum seeker's frustration was immediately discernible and this frustration increased substantially when after a physical examination the doctor asked him to have another blood test and an X-ray, to rule out rheumatoid arthritis. The patient started arguing with the doctor, saying that he had already taken a lot of blood investigations that had left him feeling weak and what he needed now was medicine that would cure him. After arguing for a while the patient seemed to realise that he could not convince the doctor otherwise, so he just said okay and left, with the great probability of forgoing any further investigations or medical visits. This example clearly demonstrates how this patient's experience of past encounters with doctors who failed to successfully address his symptoms, resulted in mistrust. Furthermore, whilst this last doctor did try to explain the rationale behind the decision for further investigations, he did not attempt to elicit the asylum seeker's own expectations or understanding of his symptoms, which might have helped achieve some degree of mutual understanding (Deville et al, 2011).

Refugees often experience frustration when a diagnosis is not made, despite numerous investigations being taken (Cheng et al, 2015). Pavlish et al (2010) reported that Somali women who participated in their study showed expectations of treatment being initiated on their first visit to the doctor. Other studies further revealed refugees' expectations of being given prescription medication (Carroll et al, 2007), especially in relation to antibiotics (O'Donnell et al, 2007). Whilst the asylum seekers in this present study reported that they did not feel disappointed when medication was not prescribed, the way that some of the asylum seekers stressed how '*they did not even give me anything*' when describing specific healthcare encounters seems to belie this assertion. However, this latter observation should be regarded with caution, in view of the possibility of meanings being misconstrued as a result of language discordance and interpreted interviews. On the other hand, the majority of the doctors in my study maintained that asylum seekers would generally want antibiotics irrespective of their ailment and as the findings in Chapter Six show, some of these doctors claimed to have developed specific questioning strategies which they believed helped ascertain the asylum seekers' true symptoms. The expectations that asylum seekers had of being prescribed antibiotics also occasionally emerged during my observations of clinical encounters and whilst most of these patients appeared to accept the doctors' explanations when antibiotics were not prescribed, a few did not. In these latter cases, the asylum seekers' responses insinuated that the doctors were acting in this way because they were racist and disliked asylum seekers. Tarrant, Dixon-Woods, Colman & Stokes (2010) reported that one of the factors associated with judging a doctor's trustworthiness, is the patient's perception of the doctor's willingness to "act in the patient's best interests" (p 443) but in view of the responses described above, this idea of the doctor's 'willingness' was far from the perceptions of some of these asylum seekers.

Continuity of Care

A lack of continuity has been highlighted as a major barrier to migrants building trust in HCPs (Boateng et al, 2012), although findings from a study that utilised a heterogeneous sample of primary healthcare patients showed that continuity of care in terms of being seen by the same general practitioner, was far from the sole determinant of trust (Tarrant, Colman & Stokes, 2008). The benefits of continuity of care is highlighted by Simret,

whose narration shows the great value that he places on the personalised greetings which he gets from the nurses at the Healthcare Centre that he usually frequents. Nonetheless, whilst discussing what for him determined good healthcare experiences, Simret also referred to medical encounters where the doctors whom he had never met before acted civilly and equitably, appeared genuinely interested in him and provided full information.

A substantial number of the healthcare staff, especially the nurses, also described how a patient's trust develops from an initial healthcare encounter that is deemed by the asylum seeker to be satisfactory and is further strengthened in subsequent encounters. So much so that the majority of the female HCPs proudly reported how a number of the male asylum seekers would view them with distrust initially because of their gender but following their performing the needed intervention, would be specifically asked for by these male asylum seekers at subsequent visits. A lack of continuity was highlighted as a problem by a number of the doctors, who as mentioned previously, further reported how these situations were aggravated by the common occurrence of patients' files going missing. In the doctors' case, their concern was not related to the development of interpersonal relationships but because of their perceptions of asylum seekers failing to turn up for follow up appointments. This is evidenced in Chapter Five, which presents a doctor's description of how when faced with asylum seekers, he tends to investigate any suspicion of illness he might have, whilst if he was attending to a non-migrant, he would wait a few days to see how the illness proceeded prior to taking investigations.

Three different types of continuity have been identified, namely "longitudinal continuity", "caring relationships between patients and professionals" and "well-coordinated care", with the context dictating the specific type of continuity that could be achieved (Salisbury, Sampson & Ridd, 2009, p e134). The nature of the 'walk-in' clinic in the Health Centres in Malta is not conducive to "longitudinal continuity", both in terms of patients being attended to by different doctors and patient documentation that cannot be found. Whilst none of the asylum seekers whom I interviewed raised this as a problematic issue, as can be seen from the above, this was a matter of concern for a number of doctors. The negative impact of this on offers and resistance was also evident during observation, mainly as a result of communication discordance. The development of "caring relationships between

patients and professionals” emerged as an important issue amongst the asylum seekers of this present study and the HCPs’ in Priebe et al’s (2011) study affirmed a strong association between continuity of care and the development of positive relationships with migrants. Notwithstanding this, Feldmann et al (2007) reported that a major determinant was the HCP’s approach and furthermore, a systematic review that explored the relationship between continuity and patient satisfaction, showed that whilst continuity did have some bearing on patient satisfaction, “interpersonal communication”, “trust” and “choice”, were found to have a stronger association (Adler, Vasiliadis & Bickell, 2010, p176), with trust and effective communication having a direct impact on patient compliance to offers (Feldmann et al, 2007). “Well-coordinated care” is the third type of continuity identified by Salisbury et al and refers to intra and interprofessional teamwork, as well as “seamless” (p 135) coordination between the diverse healthcare clinics themselves and between these clinics and other relevant institutions. There are situations described in the findings of the present study that suggest a lack of “well-coordinated care” as defined by Salisbury et al. As has been shown in a previous section, this has a negative impact on service permeability, which in turn determines the amount and nature of resources that asylum seekers require to successfully access healthcare services.

Adjudications and Offers and Resistance: A Conceptual Overview

As can be seen from the above discussion, notions of deservingness are what guide HCPs’ adjudications and subsequent offers and these notions have been shown to be ambivalent and based on socially constructed stereotypical assumptions, with healthcare provision to asylum seekers generally viewed as the charitable thing to do, despite fears of health service unsustainability. The perspective of free healthcare provision to asylum seekers as a charitable act as opposed to a human right perspective has arisen from a colonialist image of Africans as poor and needy, which results in adjudications and offers being influenced by visual evidence of need and asylum seekers’ show of gratitude for these ‘charitable acts’. On the other hand, asylum seekers’ resistance to offers is mainly based on the trust, or the lack thereof, that they have both in the system and in the attending healthcare professional. Trust in the attending HCP is the most influential of these two, and this study shows that this is dependent on whether their expectations of an individualised and holistic

approach to care have been reached, in addition to the prescription of an effective strategy for the presenting medical complaint. The specific nature and level of these expectations are dependent on the asylum seekers' past experiences in their country of origin, the transit countries and in Malta, all of which impact on the dynamics within the healthcare encounter. The utilisation of a postcolonial and an intersectional viewpoint has shown that healthcare encounters are the sites within which adjudications, offers and resistance are formed through a series of endeavours in an attempt to achieve mutual understanding and resolution and are subconsciously shaped by dominant discourses, structures and intersecting categories.

Operating Conditions and Local Production of Candidacy

Dixon-Woods et al (2006) defined this seventh and last dimension as the “contingent and locally specific influences on interactions between practitioners and patients” (np), which refers to the impact that the various levels of influence have on candidacy and healthcare encounters within the specific and current context. An example of this would be how current discourses of ‘illegality’, unsustainability of health services and deservingness, have resulted in a new set of guidelines in relation to public healthcare entitlement in Malta. These guidelines specifically state that “regular migrants or refugees and their dependents”, are one of the patient categories that are entitled to free healthcare (Ministry of Health, n.d., n.p.). As mentioned elsewhere, in Malta there are a substantial number of migrants whose application for refugee status has been rejected on appeal but due to logistical reasons have not been repatriated and are therefore ‘failed asylum seekers’. These, as well as those migrants who have overstayed their visas, do not fall under the above-mentioned criterion for healthcare entitlement. However, in an email communication with a person in top management of the relevant government department, I was informed that in practice, “illegal/irregular” migrants are provided with the healthcare services that they require, despite the fact that there is no written policy to this effect. This seems to suggest that these ‘failed asylum seekers’ are undeserving of, and therefore, do not have a right to free healthcare and whilst this is presently being provided as an ‘act of benevolence’, it could be withdrawn at any time.

The public health entitlement guidelines were introduced following my data collection period and because of this, I do not have any data of the impact of these guidelines on asylum seeker access in Malta. Notwithstanding this, there is evidence that shows how similar policies elsewhere, which were possibly introduced in an unsuccessful attempt to deter future asylum seekers (Taylor, 2009), compound existent inequalities not only through the obvious direct negative impact that these policies have on access, but also on limiting asylum seeker utilisation because of feelings of intimidation that these policies could produce (Kelley & Stevenson, 2006). Additionally, these policies have been shown to intensify the challenges that HCPs face when caring for asylum seekers, as they are placed in positions where they are expected to pass value judgements on who is deserving of care and who is not (Taylor) and in so doing, act in a manner that is in conflict with their professional ethical codes (Hall, 2006).

Operating Conditions and Local Production of Candidacy: A Conceptual Overview

This dimension clearly shows how dominant discourses at the macro level shape policy and social structures at the meso level, which in turn influence clinical encounters at the micro level. Additionally, these interactions are played out within a backdrop of a variety of intersecting elements such as skin colour, ethnicity, level of education and socio-economic circumstances and uncertainty, stereotypes and biases, self-identity, agency, ethical conflicts and trust/distrust. The complexity of this chaotic bricolage is further convoluted with the power differentials at play and the variety of outcomes that intersectionality reaps. In turn, the outcomes influence discourses and structures that then determine future candidacy practices on the part of the three stakeholders, namely the asylum seekers, the healthcare professionals and the healthcare system.

Recursive Cascades of Influence: A Conceptual framework

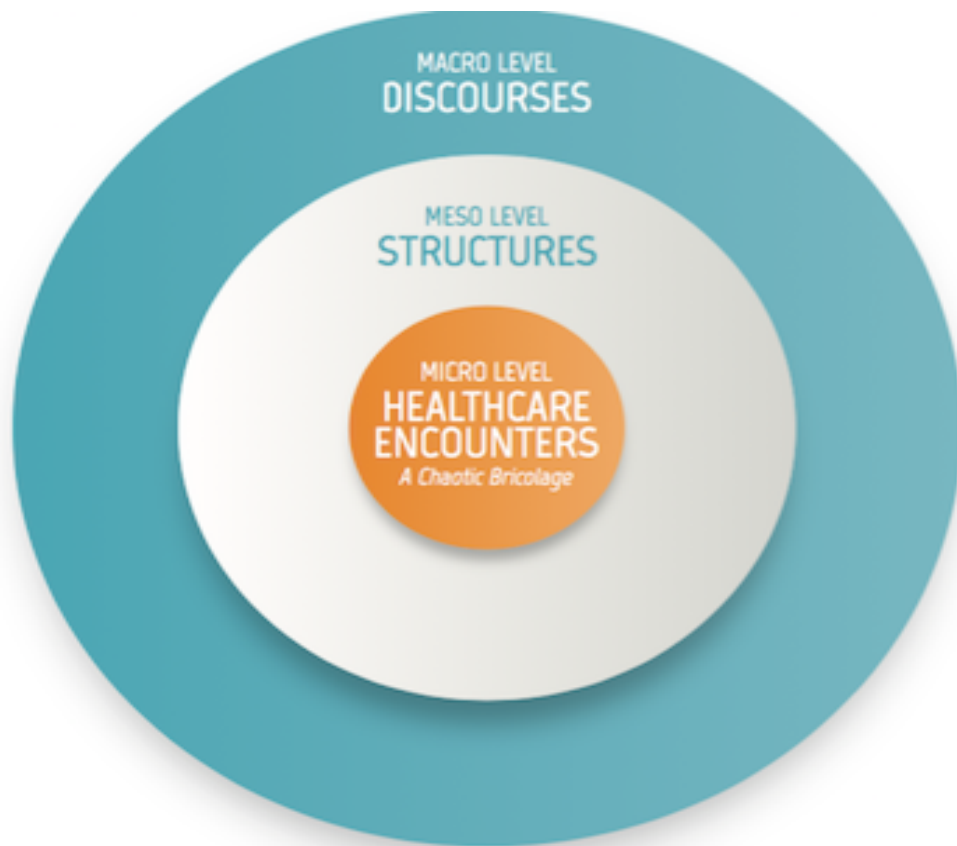


Figure 2: Conceptual Generic framework

The framework as presented in Figure 2 has emerged following an analysis of the findings utilising the candidacy framework as developed by Dixon-Woods et al (2005) and with added consideration given to one of the refinements suggested by MacKenzie et al (2013). This specific refinement places an extra emphasis on the cyclical nature of candidacy, which “brings to the fore the embeddedness of micro-level negotiations between service-users and professionals in their local/organisational (meso) and national/political (macro) contexts” (p 820). The critical viewpoint provided by a postcolonial lens in combination with intersectionality, has enabled the identification of various dominant discourses at the macro level (Figure 3), which intertwine in a synergistic and interdependent manner with the social structures at the meso level (figure 4). It is this process which produces the chaotic bricolage that is representative of the heterogeneous factors at play during each

crosscultural healthcare encounter at the micro level (Figure 5) and that in turn, reinforces existent discourses and structures on the other two levels.

The Macro Level: Dominant Discourses

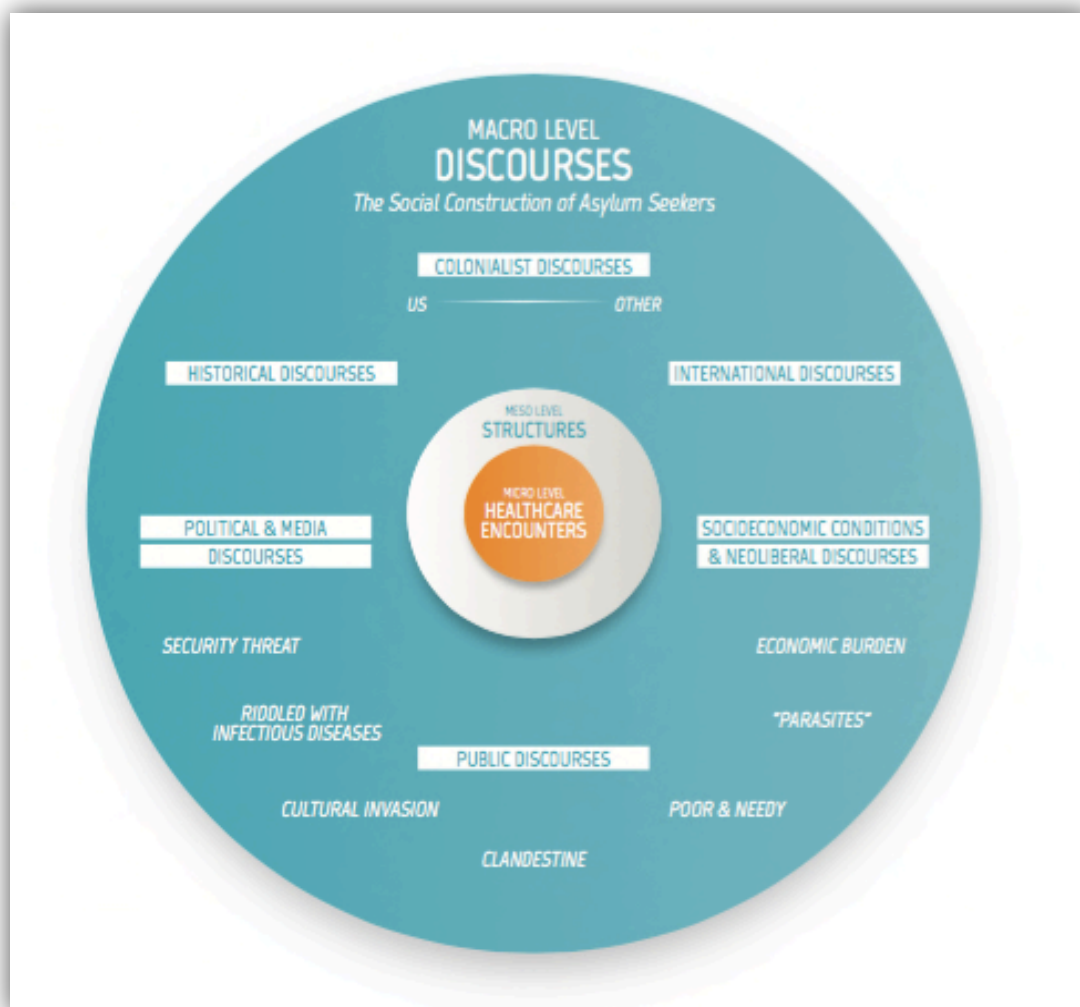


Figure 3: Influential Discourses at the Macro level

The discussion is littered with examples which show how a dominant discourse based on colonialist constructions of extreme binaries such as ‘Us’ and ‘Other’ and unquestioned Eurocentric notions of ‘Western supremacy’, infiltrate through other influential discourses and then interact with structures at the meso level, all of which strongly impact healthcare interactions between asylum seekers and HCPs.

The findings and ensuing discussion show how historical and colonial discourses of Africans as ‘poor and needy’ have resulted in judgments being passed by HCPs on notions of asylum seeker identities as being deserving or undeserving, depending on appearances. Additionally, socioeconomic conditions have guided international, neoliberal, political and public discourses of asylum seekers being an unsustainable burden, which has resulted in some unclear healthcare policies. Whilst to date all asylum seekers have their healthcare needs attended to free of charge, for the ones on a rejected status this is not an officially recognised entitlement and appears to be provided on sufferance, as opposed to a human right and could therefore be removed at whim.

Another example of the impact of colonial discourses is evident in HCPs’ self-protective practices in relation to ‘black’ asylum seekers, in the belief that these are riddled with disease. As the discussion shows, the impact of this discourse does not solely result in stereotypical notions and discriminatory healthcare practices but also in a reluctance on the part of asylum seekers to seek healthcare because of a fear of stigmatisation, or corroboration of HCPs’ stereotypical perceptions. The discussion also highlighted the fear of a cultural invasion, to a great part related to Islamophobic responses in a country that proclaims to consist of a vast majority of Roman Catholics. This belief in ‘Western superiority’ and a fear of a ‘cultural invasion’ has resulted in asylum seekers being expected to adapt to and assimilate, unquestioned ‘Westernised norms’.

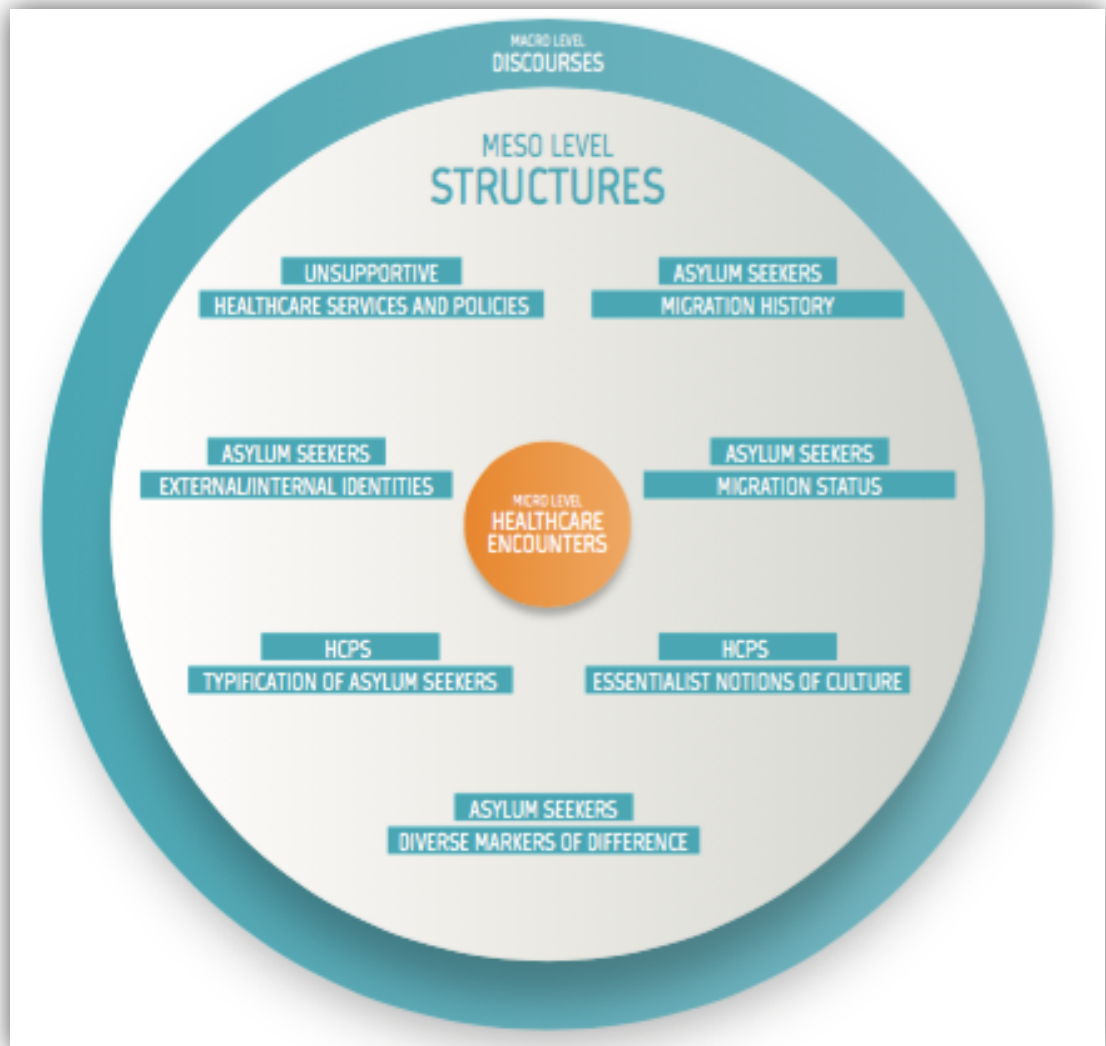


Figure 4: Influential Structures at the Meso level

In this specific context, social structures refer to factors associated with the impact of healthcare policy and services and notional relationships between asylum seekers and HCPs, both of which as discussed above, are greatly influenced by colonialist and other dominant discourses at the macro level. One of the examples that emerge from the discussion is how HCPs' notions of culture as static and essentialising, which arises from a colonialist discourse of 'Other', results in the stereotyping of asylum seekers that greatly impacts healthcare encounters. Additionally, the stereotypical and negative connotations associated with the term 'asylum seeker' as a result of the dominant discourses, are also

detrimental to asylum seekers' healthcare access and utilisation. These often result in the asylum seekers' failure to address their healthcare needs because of notions of eligibility that are shaped by their expectations of the HCPs' negative responses.

The utilisation of an intersectionality lens, in association with a colonialist discourse of 'Other' and a public discourse of 'cultural invasion', has also helped highlight how markers of difference such as skin colour, language, religion, education and socioeconomic status, determine at what level of the hierarchy HCPs would place asylum seekers, with those with a higher number of differences being placed on lower scales.

The Micro Level: Healthcare Encounters – A Chaotic Bricolage

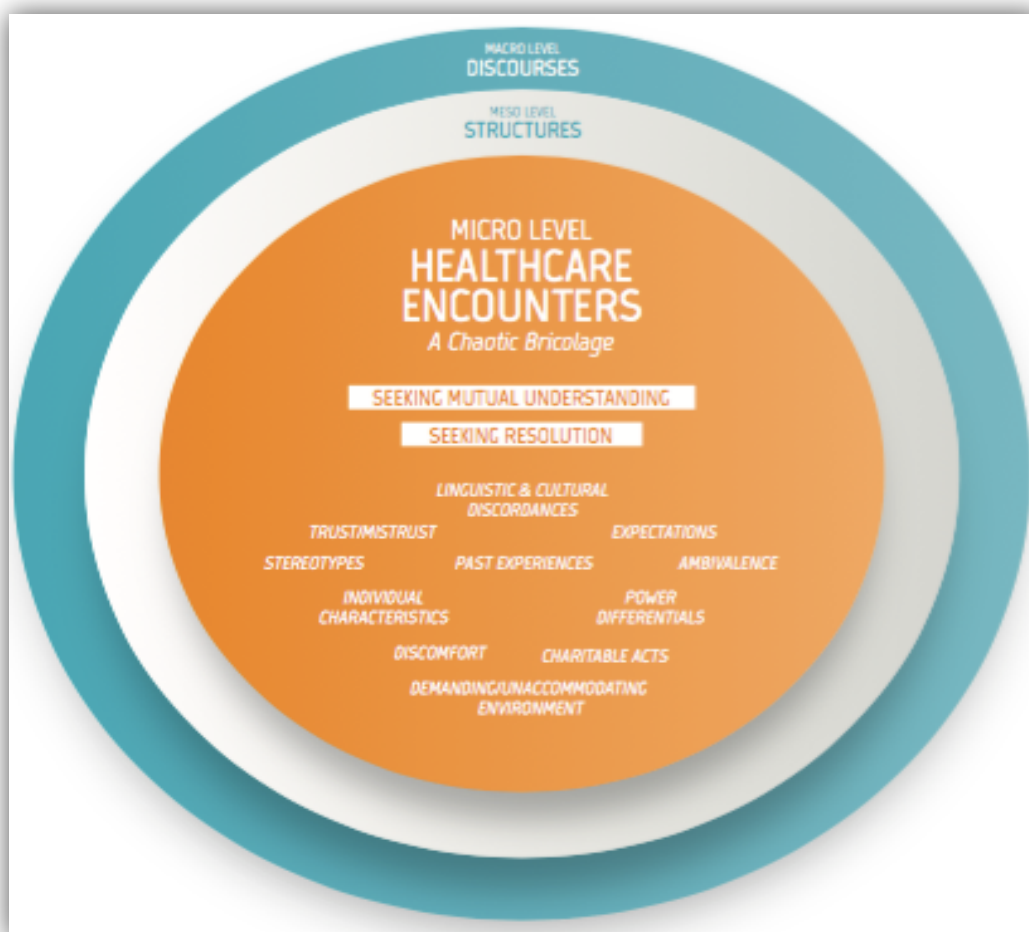


Figure 5: Healthcare Encounters - A Chaotic Bricolage

Figure 5 illustrates the multiple divergent factors that could be present, often subconsciously, which impact crosscultural healthcare interactions as presented in the findings and further elaborated upon in this chapter. The term chaotic bricolage was chosen because it clearly depicts the complexity of factors that intertwine, often disharmoniously, as both asylum seekers and HCPs seek to achieve resolution to the presenting problem.

Summary

This chapter has provided an analysis of candidacy in the context of asylum seekers and healthcare encounters in the era of mass migration, through a combined postcolonial and intersectionality perspective. As can be seen from the discussion and the above framework, healthcare encounters are shaped by dominant discourses and structures, as they give rise to a number of factors that hinder the mutual understanding and resolution of the presenting problems, which both the asylum seekers and the healthcare professionals seek. These factors include power differentials, stereotypes and biases, uncertainty and issues of trust and mistrust, all of which are aggravated by an unsupportive organisational structure and environment, past experiences and incongruent expectations. The term chaotic bricolage has been chosen as a representation of the dissonance that is virtually palpable in these crosscultural healthcare encounters and truly illustrates these interactions, which are enmeshed in ambiguity and wherein the players are often subconsciously driven by contradictory forces.

The following chapter provides an overview of clinical encounters as explored through a critical perspective and recommendations for practice and research.

Chapter Eight: Implications and Recommendations for Healthcare Research, Education, Practice and Policy

Introduction

This study aimed to gain an insight into cross-cultural healthcare practices and provision through an exploration of clinical encounters between asylum seekers and HCPs in the Maltese PHC setting. This chapter firstly discusses how an exploration of cross-cultural encounters through a critical lens has enabled a fuller understanding of the impact of both individual and structural influences on primary health care encounters, resulting in a significant contribution to knowledge. Next, a brief outline of recommendations for healthcare research, education, practice and policy is presented.

Cross-cultural Healthcare Encounters Through a Critical Lens

The literature review in Chapter Two discussed the findings of selected studies that explored migrant healthcare utilisation and provision, revealing a variety of factors, such as trust issues, divergent understandings of health and illness and varied expectations that intersect to shape healthcare encounters with migrants in the PHC setting. For the most part, these studies failed to fully explore broader contextual and structural influences on healthcare encounters and focused solely on participants' behaviours and interactions, with the result that culturalist explanations were generally given for any cross-cultural discordances. The present study adopted a novel approach, using postcolonial and intersectionality theories within a candidacy framework to help address the shortcomings in existing research that generally fails to go beyond essentialist explanations and in so doing, further reinforces a colonial legacy of 'Us' and 'Them'.

The innovative combination of these three conceptual perspectives has forged new inroads to knowledge through findings that exposed the historical and current dominant discourses and further showed how these give structure to the contemporary, socio-cultural and economic context in Malta. In turn, this context produces a variety of elements including linguistic and cultural discordance, trust/mistrust issues, incongruent expectations and unaccommodating environments that influence interactions within cross-cultural healthcare encounters. Whilst several of these elements have been identified in the findings of the

previously reviewed studies, the critical lens utilised in the present study has helped reveal the intersection of these with other highly influential components present within healthcare encounters, namely HCPs' adjudications of asylum seekers' deservedness and the power differentials between asylum seekers and HCPs. It is within this chaotic bricolage that asylum seekers and HCPs seek to achieve mutual understanding and ultimately, a satisfactory resolution.

Intersectionality theory has further helped show how asylum seekers are a highly heterogeneous group with each individual pre- and post-migration history resulting in positional differences and divergent healthcare needs, expectations and experiences. This heterogeneity invalidates the widely accepted notion that asylum seekers can be boxed into a cultural paradigm and moreover, challenges the provision of healthcare through a monistic health system. Indeed, whilst the literature review in Chapter Two highlighted the predominance of biomedical health systems in 'Western' medicine and additionally discussed the benefits associated with the utilization of social models of healthcare delivery, findings from this study strongly suggest going beyond utilizing any one model, as asylum seekers' divergent healthcare expectations require a system that is pluralistic and flexible and that would enable a sensitive and effective response to this diversity.

In recognition of the potential for research to reinforce power asymmetries and reproduce unchallenged 'Western' epistemology, a critical approach prompts the researcher to address existent power imbalances and issues of representation. As evidenced in Chapter Three, these two issues were taken into consideration throughout the research process and have therefore greatly influenced methodological decisions taken and ethical practices adopted. This has led to the development of a process that has been guided by a research ethic that challenges 'Western' epistemology as the sole truth and has resulted in sensitive research measures and equitable research encounters, based on a reflexive understanding of self in relation to various aspects of the research study. Therefore, it is anticipated that the ethical processes utilised in this study can be drawn upon for future research that is carried out with oppressed and vulnerable populations. Additionally, findings from this study have highlighted how the common practice of universalising ethical 'Western' principles by ethic review committees, could result in Eurocentric regulations that are problematic in non-Western populations, causing harm to the very people they purport to protect.

As illustrated by the multilevel framework entitled “Recursive Cascades of Influence” presented in the previous chapter, this thesis argues that healthcare encounters between asylum seekers and HCPs in the Maltese PHC setting are shaped by processes that are borne out of essentialist notions of culture and a belief in ‘Western’ knowledge as the ultimate truth. These notions are the product of historical, international, political, media and public discourses, which are formed through the colonialist creation of ‘Us’ and ‘Other’ and that further serve to construct ‘asylum seekers’ as poor and needy and as being an economic, cultural, health and security threat. In turn, the social construction of ‘asylum seekers’ guides national and institutional policies, shapes public responses and impacts on asylum seekers’ negotiation of self-identity, all of which have a bearing on the social determinants of health and ultimately on healthcare encounters. Whilst the framework “Recursive Cascades of Influence” provides a detailed conceptual illustration of this thesis, it is envisaged that the basic idea underlying this framework namely, that encounters are a product of the synergistic process that occurs between the relevant dominant discourses, various structures and interpersonal interactions, could be utilized to guide future healthcare research. Indeed, migrant health is a major global issue and this framework could be applied in a range of geographic, political contexts, avoiding the limitations of existing ways of thinking and leading to informed practice.

From Theory to Practice

‘Our responsibility as academics, writers and intellectuals, for which we are accountable, is to link our work to the many issues of injustice and inequality operating in the world today and to direct our work towards the righting of such wrongs and the transformation of the systems that produce them’

(Young, 1999, p30)

Atkins (2004) highlighted the futility and danger of presenting problems associated with cross-cultural healthcare practices, without any attempt to provide potential solutions to these problems. Moreover, a critical and postcolonial approach to research demands that health inequalities which emerge from the research study are addressed (Racine, 2002). It is in view of this and in consideration of the findings that the following sections will present recommendations for healthcare research, education, practice and policy.

Recommendations for Research

The present study confirms that the utilisation of a critical lens to explore cross-cultural healthcare encounters, minimizes the risk of producing findings that provide oversimplistic culturalist explanations and which have the potential to reinforce the opposing binaries of 'Us' and the 'Other' and current 'Othering' healthcare practices. It is therefore essential that any research of this nature is guided by a perspective that utilises a critical constructivist position to highlight discriminatory healthcare policies and practices within the relevant historical, political, economic and socio-cultural context.

The present study highlighted various ethical difficulties that arose throughout the research process because of regulatory impositions that used ethical guidelines instructed by 'Western' principles to guide research with 'non-Western' populations. It is in view of this that further research in relation to alternative ethical views and approaches, is advocated. The findings could then serve to identify appropriate ethical guidelines and enable sensitive practices and in so doing, eliminate the current imposition of hegemonic practices.

Whilst the results of the present study may be applicable to both the PHC and hospital settings in Malta, this cannot be automatically assumed. It would therefore be beneficial to undertake research in a hospital setting to determine if the diverse setting produces different outcomes. Additionally, It would be advisable for a study of this nature to utilise the "recursive cascades of influence" framework as discussed in the above section, which would enable a true comparison of crosscultural healthcare utilisation and provision in the primary and tertiary settings in Malta.

Since the collection of data for this study, the pattern of migration of asylum seekers to Malta has changed in terms of modes of travel, modes of entry and the countries of origin of individuals applying for refugee status. The political context is also dynamic. While a more tolerant attitude to migrants was evident following the push back threat in 2013, in November 2016 political discourses of illegality were re-ignited in Malta when 32 rejected asylum seekers were arrested and thrown into detention, despite having police permits. In view of this and in view of the findings of this present study that highlighted the impact of dominant discourses and social structures on healthcare utilization and provision, it would

be beneficial for further research to be carried out to additionally examine the impact that diverse migratory patterns and shifting political discourses have on cross-cultural healthcare encounters.

Recommendations for Education

Individual practitioners need to be encouraged to critically reflect on their practice in cross-cultural healthcare. The findings demonstrate a need to provide undergraduate and postgraduate educational opportunities that enable HCP reflexivity in relation to cross-cultural encounters and with an additional focus on patient empowerment.

Education programmes should encourage students to acknowledge social and structural inequities and the impact of these inequities throughout the various stages of the healthcare pathway. This could be achieved through a social justice curriculum that would help students develop a vision of healthcare practice that goes beyond a biomedical model, promoting an awareness of the broader determinants of health and illness, as well as the practitioner's advocacy role in addressing multiple inequities.

There is also clear need for healthcare professional training in relation to triadic healthcare encounters and the appropriate use of cultural mediators.

Information sessions for asylum seekers in relation to available healthcare and social services and entitlements and issues related to access, should also be provided. In addition to these sessions being carried out in the Open Centres, it would also be beneficial if these are also organised and delivered in town and village centres.

Recommendations for Healthcare Practice and Policy

The thesis has identified both individual and institutional racisms structuring healthcare encounters. It is essential that both these forms of racism are addressed by the identification and implementation of institutional policies that propagate an equitable healthcare system through the availability of services such as accessible cultural mediators of both genders, and amending complex appointment systems and restricted hours of service to make these more permeable for asylum seekers.

At the present time, planning and providing healthcare services for asylum seekers is

hampered by a lack of data. There is inadequate information about the number of asylum seekers attending the various health centres, patterns of attendance and the nature of the presenting medical problem. This hinders service planning, resource allocation and staff deployment. It is therefore recommended that an effective information system is identified and introduced, which would collect the necessary information, enabling management to devise a service that is more responsive to the needs of asylum seekers.

The findings show how negative discourses surrounding the term ‘asylum seeker’ help construct a collective and stereotyped identity that results in the marginalisation of asylum seekers from the rest of Maltese society and impacts on the social determinants of health. A number of non-governmental humanitarian organisations do address some of these issues and provide their recommendations to the government of Malta, but there is no guarantee that such recommendations are given due consideration. It would therefore be beneficial to establish an official national working group to assume a watchdog role in relation to dangerous discourses which might impact negatively on asylum seekers’ positionalities. Moreover, such a working group could advise government on devising policies that address the broader social determinants of asylum seeker health.

It is beyond the scope of this thesis to discuss multilevel policies in detail. Notwithstanding this, the theoretical approach utilised by this study has clearly demonstrated that in order to help healthcare professionals provide appropriate and effective primary care to asylum seekers during healthcare encounters, the broader structures and discourses on the meso and macro levels need to be acknowledged and addressed.

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Appendix 1 : Participant Information Sheet – Healthcare Professionals

DMU FREC 988; UOM UREC 118/2012: Version 2: 2012

An exploration of clinical healthcare encounters with African Migrants in the Primary Health Care setting

I would like to invite you to participate in a study that I am carrying out and here is some information about it. Thank you for taking the time to read this and for considering to be part of this study.

Purpose of the Study

My name is Joanna Depares and I am a PhD student at De Montfort University, Leicester, UK. The doctoral study that I am carrying out, aims to gain an understanding of crosscultural healthcare practices through observation of clinical encounters between you and African migrants in the Primary Health Care setting and through hearing about your, the migrants' and the cultural mediators' experiences of these encounters. Following this, I will analyse the information that I have gathered in relation to crosscultural healthcare policy, practice and education.

Why are you being invited to participate?

You have been asked to participate because you are a healthcare professional who provides care for African migrants within a primary health care setting and therefore, are in a position to provide valuable information for the purpose of my study.

What does participation involve?

The first part of the study will involve observation and for this, I will be present when you are providing care to African migrants. I will not intrude in the process in any way and you can ask me to leave the session at any time. I will observe activities and interactions and I will be taking handwritten notes of my observations. I plan to spend a total of 100 hours of observation divided between two Health Centres and this observation will take place from August 2012 till December 2013. Although I might need to come back for minimal observation periods during the analysis stage (January 2014 – January 2015). Additionally, relevant information that is gathered during informal conversations will be used for the purpose of this study, unless you object to this. If you agree to participate, you will be asked to sign a consent form and this will show your agreement to be a participant for that whole period, although as explained below, you may choose to stop your participation at any time.

Between March 2013 and December 2013, there is a possibility that I will contact you to invite you to participate in a one-to-one interview, which would take approximately 1 hour. This interview will focus on your experiences of caring for African migrants. An appointment for this will be held at a time that is convenient for you and in a location of your choice. This interview will be audio-taped, unless you have any objections to this and if so, handwritten notes will be taken instead. If you agree to be interviewed, I will ask you to sign a separate consent form, showing your agreement to participate in this interview.

Will all the information collected be kept confidential?

I will make sure that confidentiality will be kept throughout my study and that all the material that has been collected (notes and tapes), will be stored in a locked drawer, to

which I only have access. Any computerised information will be kept on my personal computer and one external hard drive, which will also be kept in a locked drawer and both will be password protected. The only other persons apart from myself, who might possibly have access to this information are my academic supervisors.

Will your identity be protected?

I will ensure that everyone's identity will be protected and I plan to achieve this by replacing your real name with a pseudonym and I will also do this for anyone that you might mention during any informal conversations and/or interview.

What if you want to stop taking part?

Participation is totally voluntary and you can choose to stop participating at any time, without providing me with any justification for this, or with any negative repercussions. This means that if you withdraw from the study, I will not collect any further data related to you during observation and I will not contact you to participate in an interview. I will also refrain from using any previous data collected that is directly related to you, if you request this within 10 days of the data collection.

Will I come to any harm as a result of participating in this study?

I do not anticipate that you will come to any harm and if at any phase of the observations you are feeling uncomfortable by my presence, you can ask me to withdraw.

Are there any benefits of participating in this study?

It is hoped that the findings, which will be disseminated amongst relevant stakeholders, will provide a valuable source of information for policy, practice and educational initiatives appropriate to the local context that will be of benefit to you, as well as the African migrants under your care.

What will happen to the finalised study?

The finalised dissertation will be available to the public and findings might be presented at conferences, as well as disseminated amongst stakeholders. The findings will also contain direct quotes but these will be totally anonymised. If you are interested in knowing what the findings show, a copy of the dissertation will be available at the University of Malta library, or alternatively you could contact me and I will send you a report of the findings.

Retention of Records

Audiotapes will be erased on completion of the study, whilst the notes will be retained for 8 years.

What if I wish to complain?

Complaints can be made on 3 levels and any complaints that you may have, can be forwarded to myself, my supervisor, or the DMU ethics chair, as you see fit. Contact details are provided below.

Researcher

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Faculty of Health Science

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Please do not hesitate to contact my supervisor or myself, if you have any further questions.

Appendix 2: Informed Consent Form – Observation

DMU FREC 988; UOM UREC 118/2012: Version 2: 2012

An exploration of clinical healthcare encounters with African migrants in the Primary Health Care setting

Please read the following and initial each box to show that you agree to each issue.

| Issue | Participant Initials |
|---|-----------------------------|
| I am over 18 years old and I voluntarily accept to participate in the above-mentioned study being carried out by Ms Joanna Depares for her doctoral studies with De Montfort University, Leicester, UK | |
| I have read and understood the information sheet and am aware of my rights and obligations as a participant | |
| Any further questions that I have had about this research project have been satisfactorily answered | |
| I understand that I am accepting to be observed for the length of the observation period and that handwritten notes will be taken of these observations | |
| I understand that the researcher might engage in conversation with me and any relevant information that emerges from these conversations could be used for the purpose of this study, unless otherwise directed by myself | |
| I understand that I am free to withdraw my participation at any time, with no negative repercussions | |
| I understand that I can ask the researcher to refrain from using any previous data collected that is directly related to myself, if I make this request within 10 days of the data collection | |
| I understand that I can ask the researcher to leave the clinical session at any time | |
| I understand that my personal identity will be protected at all times | |
| I have been assured that all information collected will be kept totally confidential and will not be discussed by the researcher outside of the research study | |
| I am aware that direct quotations might be used in the final | |

| | |
|--|--|
| results, conference presentations, or future publications but that these will be anonymous | |
| I agree to the researcher contacting me at a later date for an interview | |
| I have been assured that the researcher, or her supervisor will answer any future questions that I might have and contact details have been provided | |

Participant Name (in capital letters) _____

Signature _____

Date _____

Researcher Signature _____

Date _____

Supervisor Signature _____



Date _____

Contact Details

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Appendix 3: Participant Information Sheet – Asylum Seekers

DMU FREC 988; UOM UREC 118/2012: Version 2: 2012

An exploration of clinical healthcare encounters with African Migrants in the Primary Health Care setting

I would like to invite you to participate in a study that I am carrying out and here is some information about it. Thank you for taking the time to read this and for considering to be part of this study.

Purpose of the Study

My name is Joanna Depares and I am a PhD student at De Montfort University, Leicester, UK. The doctoral study that I am carrying out, aims to gain an understanding of cross-cultural healthcare practices through observation of clinical encounters between you and healthcare professionals in the Primary Health Care setting and through hearing about your, healthcare professionals' and cultural mediators' experiences of these encounters. Following this, I will analyse the information that I have gathered in relation to crosscultural healthcare policy, practice and education.

Why are you being invited to participate?

You have been asked to participate because you are a migrant who uses primary health care services and therefore, are in a position to provide valuable information for the purpose of my study.

What does participation involve?

The first part of the study will involve observation and for this, I will be present when you are in a clinical session with a healthcare professional/s. I will not intrude in the process in any way and you can ask me to leave the session at any time. I will observe activities and interactions and I will be taking handwritten notes of my observations. I plan to spend a total of 100 hours of observation divided between two Health Centres and this observation will take place from August 2012 till December 2013. Although I might need to come back for minimal observation periods during the analysis stage (January 2014 – January 2015). Additionally, relevant information that is gathered during informal conversations will be used for the purpose of this study, unless you object to this. If you agree to participate, you will be asked to sign a consent form and this will show your agreement to be a participant for that whole period, although as explained below, you may choose to stop your participation at any time.

Between March 2014 and December 2015, there is a possibility that I will contact you to invite you to participate in a one-on-one interview, which would take approximately 1 hour. This interview will focus on your experiences of healthcare provision in the primary healthcare setting. An appointment for this will be held at a time that is convenient for you and in a location of your choice. This interview will be audio-taped, unless you have any objections to this and if so, handwritten notes will be taken instead. If you agree to be interviewed, I will ask you to sign a separate consent form, showing your agreement to participate in this interview.

Will all the information collected be kept confidential?

I will make sure that confidentiality will be kept throughout my study and that all the material that has been collected (notes and tapes), will be stored in a locked drawer, to which I only have access. Any computerised information will be kept on my personal computer and one external hard drive, which will also be kept in a locked drawer and both will be password protected. The only other persons apart from myself, who might possibly have access to this information are my academic supervisors.

Will your identity be protected?

I will ensure that everyone's identity will be protected and I plan to achieve this by replacing your real name with a pseudonym and I will also do this for anyone that you might mention during any informal conversations and/or interview.

What if you want to stop taking part?

Participation is totally voluntary and you can choose to stop participating at any time, without telling me why, or with any negative repercussions. This means that if you withdraw from the study, I will not collect any further data related to you during observation and I will not ask you to participate in an interview. I will also refrain from using any previous data collected that is directly related to you, if you request this within 10 days of the data collection.

Will you come to any harm as a result of participating in this study?

I do not anticipate that you will come to any harm and if at any phase of the observations you are feeling uncomfortable by my presence, you can ask me to withdraw.

Are there any benefits of participating in this study?

It is hoped that the findings, which will be made available to relevant stakeholders, will provide a valuable source of information for policy, practice and educational initiatives appropriate to the local context and that could be of benefit to you, as well as to healthcare professionals.

What will happen to the finalised study?

The finalised dissertation will be available to the public and findings might be presented at conferences. The findings will also contain direct quotes but these will be totally anonymised. If you are interested in knowing what the findings show, you could contact me and I will send you a report of the findings.

Retention of Records

Audiotapes will be erased on completion of the study, whilst the notes will be retained for 8 years.

What if I wish to complain?

Complaints can be made on 3 levels and any complaints that you may have, can be forwarded to myself, my supervisor, or the DMU ethics chair, as you see fit. Contact details are provided below.

Contact details:

Researcher

Joanna Depares

Supervisor

Professor Lorraine Culley

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DMU Ethics Chair

Dr Richard Davies
Deputy Chair, Faculty Research Ethics Committee
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Room 00.19a Hawthorn Building
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Leicester, LE1 9BH, UK
[Tel:0116](tel:01162078832) 2078832
Email: rdavies@dmu.ac.uk

Faculty of Health & Life
Room 0.39a Hawthorn
De Montfort University
Leicester, LE1 9BH,
[Tel:0116](tel:01162078766) 2078766
Email: Lac@dmu.ac.uk

Please do not hesitate to contact my supervisor or myself, if you have any further questions.

Appendix 4: Interview Framework – Asylum Seekers

Introduction

Introducing self, thanking them for their participation and providing details re. study.
Reading through and explaining consent form and getting further consent to audiotape interview.

Personal Characteristics

Before I ask you about your experiences of the healthcare services it would help if I get to know you a bit better, so would you mind/would it be okay if you tell me something about yourself/ I would really like to get to know a bit more about you personally:

- How old are you?
- How long have you lived in Malta?
- Do you have any other family here?
- Where do you live?
- What is your present status?
- Where do you come from?
- What made you leave your country?
- What profession/occupation did you have back home?
- Are you working presently?

Health Status

How are you feeling with regards to your health at the moment?

Do you have a chronic illness/problem?

Would you say that your physical and mental health situation has changed since you've been in Malta.

If yes, how?

Health Service Utilization

Can you describe the first time that you used the health service?

- What was the reason?
- How did you find out where to go for your specific problem?
- Who did you go with?
- What problems, if any, did you encounter?
- In what ways, if any, were you satisfied with the service?
- In what ways, if any, were you dissatisfied with the service?
- What would have made this experience better for you?

Can you describe a situation/s (health care encounter/s), if any, when you felt that the healthcare provision experience was a good one?

What made this a good experience/s?

Can you describe a situation/s (healthcare encounter/s), if any, when you felt that the healthcare provision experience was a bad one?

What made this a bad experience/s?

Can you describe other instances, if any, when you felt that your health care needs had not been met?

What actions would you take in instances, if any, that you felt that the outcomes of your healthcare encounter were unsatisfactory?

You have mentioned a few difficulties that you encounter, are there any more that you can think of?

- Language (oral and written)
- Lack of information re. system
- Racism (personal/institutional)
- Culturally inappropriate approaches (gender issues, unacceptable treatment options, difficulty/discomfort with talking about health/body issues)

Some people say that asylum seekers are not treated in the same way as the Maltese. What do you think?

Can you tell me about the healthcare system in your country?

What differences, if any, have these differences that you describe created for you

What else would you like to tell me about health care service provision?

Thank you for giving me your time, the information that you provided will be very helpful.

Appendix 5: Interview Framework - Healthcare Professionals

How long have you been working here and could you tell me a bit about what your work involves?

Could you give a rough estimate of the proportion of patients that you see who are asylum seekers?

Generally, what are your views on the situation of asylum seekers here in Malta?

Could you describe your experiences of working with asylum seekers?

Can you think of (any other) challenges, or concerns that you face when caring for asylum seekers? (Eg: *Communication issues; mistrust; Uncertainty and intercultural anxiety; religious issues etc...*)

What strategies, if any, do you adopt to address these challenges, or concerns?

What institutional support (*eg access to culture-specific information*), if any, is presently available and what further support would you like to see?

What specific healthcare needs, if any, do you think asylum seekers have?

In what way/s, if any, do the healthcare services cater for this/these specific need/s?

Can you describe any instances where you felt that a person's culture had influenced their care preferences?

What other patient characteristics, apart from culture, influence care preferences?

Can you describe any situations that you have observed, where other staff/patients exhibited potentially problematic attitudes/actions towards asylum seekers?

What education/training, if any, have you had in relation to providing care to asylum seekers/patients from diverse cultures?

What training/preparation have you had, if any, with regards to working with cultural mediators/interpreters?

What (further) education/training would you like/you feel you need, to enable you to provide better care for your patients who are asylum seekers?

Can you think of any other resources that would help you to care for asylum seekers in the best possible way?

Is there anything that you would like to add?

Thank You

Appendix 6: Interview Framework - Cultural Mediators

Thank you for agreeing to be interviewed. To date I have carried out observation at Health Centres and I have interviewed asylum seekers about their experiences of the primary healthcare services and HCPs about their experiences of healthcare provision to asylum seekers. I have been given information that is conflicting, possibly in part because we are talking about individuals who are obviously different from each other and possibly because the way that people see things are totally different, dependent on where they are standing. I therefore would like to interview you to get your views on the situation.

Before we start with this, can you tell me a bit about yourself, such as where you are from, why you left your country, how long you have been in Malta, what job you had previously, if any etc...?

How long have you been a cultural mediator and what exactly is your present role and what does it entail?

Generally what have your experiences of healthcare utilization and provision been?

Generally, what are asylum seekers expectations of the healthcare system?

Are these expectations being met?

Are expectations different depending on where one is coming from (country), or perhaps their present residence (closed/open centres, or community) and status?

How do asylum seekers learn about the healthcare system?

Who do they trust/would they turn to, to get advice re. health issues/concerns?

When interviewed, the majority of the asylum seekers claimed that religious issues (modesty, dietary restrictions etc...) were not a concern because of religious concessions when one is ill. On the other hand, HCPs claimed that issues like modesty is a problem, what are your experiences of this?

During my observation and interviews, it appears that there is mistrust on both sides – HCPs do not always appear to trust asylum seekers to tell them the truth with regards to their medical history and asylum seekers do not always trust the healthcare professional to do his/her best. What is your experience?

What communication difficulties (apart from language), if any, arise during encounters between HCPs & asylum seekers?

HCPs feel that occasionally asylum seekers will say that they have understood what they are being told and when probed further, it becomes clear that they haven't understood.

Have you come across this and can you think of any reasons why?

Is psychological support a known concept within your culture and how is it looked upon?

One of the main issues that HCPs complain about is punctuality and asylum seekers' apparent inability to keep appointments. What is your experience about this?

Some female HCPs feel that male patients are initially disappointed to have a female nurse/doctor because they feel that the males view females as inferior. What are your experiences/thoughts of this?

Some asylum seekers feel that they get exactly the same level of treatment as the Maltese, whilst others feel that they are exposed to racism and discriminatory practice, especially in HCPs attitudes towards them? What are your experiences?

Is there a formal complaint procedure if patients feel that they have been discriminated in any way?

What do patients do when they feel dissatisfied with the service that they have been given/ they do not get what they feel they should have got? (Eg antibiotics)

In your personal opinion and from your experience, what is good about primary healthcare services for asylum seekers?

In your personal opinion and from your experience, what is bad about primary healthcare services for asylum seekers?

What problems do you encounter, whilst carrying out your work as cultural mediators?

Do you feel that HCPs should have training on how to work with cultural mediators?

Is there anything else that you would like to add?

Thank You

Appendix 7: Informed Consent Form – Interview

DMU FREC 988; UOM UREC 118/2012: Version2: 2012

An exploration of clinical healthcare encounters with asylum seekers in the Primary Health Care setting

Please read the following and initial each box to show that you agree to each issue.

| Issue | Participant Initials |
|--|-----------------------------|
| I am over 18 years old and I voluntarily accept to participate in the above-mentioned study being carried out by Ms Joanna Depares for her doctoral studies with De Montfort University, Leicester, UK | |
| I have read and understood the information sheet and am aware of my rights and obligations as a participant | |
| Any questions that I have had about this research project have been satisfactorily answered | |
| I understand that I am accepting to take part in an interview of approximately 1 hour length, in which the researcher will ask me open questions | |
| I understand that this interview will be audio-taped but I can ask the researcher to stop this recording at any stage of the interview | |
| I understand that I am free to withdraw my participation at any time of the interview, with no negative repercussions | |
| I understand that I can ask the researcher to refrain from using any data collected from this interview, if I make this request within 10 days of the data collection | |
| I understand that my personal identity will be protected at all times | |
| I am assured that all information collected will be kept totally confidential and will not be discussed by the researcher outside of the research study | |

| | |
|---|--|
| I am aware that direct quotations might be used in the final results, conference presentations, or future publications but that these will be anonymous | |
| I understand that the researcher, or her supervisor will answer any future questions that I might have and contact details have been provided | |

| | |
|--|--|
| | |
|--|--|

Participant Name (in capital
letters)_____

Signature_____

Date_____

Researcher Signature_____

Date_____

Supervisor Signature_____



Date_____

Contact Details

Researcher

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